Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year BETTYE 6:46 AM JONES JUNE 2007 10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NIA HARBOR HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min 5. Social Security Numbe 8. Date of Birth (Month, Day, 03, 15 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 1 ☐ M 2 XF 25.60.4780 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21230 Wegworth USA Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Counselor Hero 12tharade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

2741 Weaworth Lane

20b. Place of Disposition (Name of

Laura

19b. Mailing Address (Street and Number or Rural Route Number) City or Town, State, Zip Code)

Date

Baltimore MD 21230

20c. Location - City or Town, State

Physician /Medical

Physician

/Medical

Examiner

10a, State

Funeral Director

Be Completed by

MD

Alexander

Husbang

19a. Informant's Name/Relationship (Type, Print)

20a. Method of Disposition

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 ie marked other than "neturel", or items 23a or 28e-f ehow emp injury or other traumatic event, the Madigal Evantinat must be notified at once.

Baltimore, Maryland 21215-0036

Physician/Madical Evamin Re Completed by ٤ Modical Cartification.

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, after death.

Director: After this certific
J in by the funeral director, within 24 hours after To the Funeral Dil

	1 ⊠Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Bemoval from State 1	t. Zion Cev	meteni		101 Ba			
	21. Signature of Funeral Service Licer		22. Name	and Address of Fa	acility Vauc	ghn C. Gred Ultimore	ene Fun MD 212	eral sucs	
	23a. Part I. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused the deat one cause on each line.	h. Do not enter the me					Approximate Interval Between Onset and Death	
	disease or condition resulting in death)	a. PERITONI Due to (or as a conseq						3 WEEKS	
5	Sequentially list conditions, if any, leading to immediate	b. SEPSIS Due to (or as a conseq	juence of):					3 WEEKS	
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. DIFFUSE Due to (or as a conseq	HEMORRA Juence of):	HAGIC	GAST	RITIS		2 Days	
	•	_ d							
,	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ★ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	al death 3 Ectopic				23d. Date of de Month	elivery Day Year	
	Part II. Other significant conditions of			g cause given in P	art I.	23e. Did tobacco		to the cause of death? Probably 4 □Unknown	
						24a. Was an autopsy performed?	prior to death?	autopsy findings available completion of cause of us 2 ½ No	
	25. Was case referred to medical examiner?					Check only one)			
	1 ☐ Yes 2 X No	Hospital: 1 Inpatient 2	ER/Outpatient 3 0	DOA Other: 4	Nursing Home	e 5 ☐ Residence	6 ☐Other (Sp	ecify)	
	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio		28b. Time of Injury M	28c. Injury at Work? 1 Tyes 2	28	d. Describe how inj			
	3 Suicide 6 Could not b 4 Homicide determined		ome, farm, street, factory)	ory, office	28	f. Location (Street a City or Town, Sta		Rural Route Number,	
	29a. Certifier (Check only one) 1 Certifying Pt 2 Medical Example (Check only one)	hysician: To the best of my knominer; On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date on, in my opinion,	e and place, and death occurred	d due to the cause(I at the time, date ar	s) and manner and place, and du	is stated. ie to the cause(s)	
	29b. Signature and title of certifier	PHYSICIAN	2	PES O			ale signed (Mor	nth, Day, Year)	
	30. Name and address of person who 3001 SOUTH				-	AMED, M			
	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	P)	JOKE ,	MD 21	3 <i>3</i> 25		
JUN 1 6 2007 1 2000 10 17									

DHMH 17 Rev 1/2001

10

State Registra

			State of Maryland / Department of Health and M 1- State Amend #19a, perInf, 6868, 6/22/07 VI/Tertificate of Death	-	
			· · · · · · · · · · · · · · · · · · ·		
	Physici	an	1. Decedent's Name (First, Middle, Last)	Date of Death Month	Day Year 3. Time of Death
	/Medic		Hubert Francis Kalb	June	14, 2007 4:20 P ^M
	Examir	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death
			Stella Maris Timonium 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.	O. Data of Birth	Baltimore
	Funeral		Months Days Hours Min.	8. Date of Birth (Month, Day, Y	
	Director		220-12-4681	Oct 8,	1925 Maryland
	death with the Maryland ms 23s or 28s-f show Littlet be notified at		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Mary	to	Md. Baltimore Essex		1 ☐ Yes 2 ☐ No
M	r 288	Funeral Director	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Country?
A	38 o	D D	810 Creek Road 21221		U.S.A.
:20	death ms 2	Jer	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - American Indian,
	after or ite		Armed Forces? If Yes, specify Cuban, Mexican, Puerto 1 □ Never Married 2 □ Married 1 □ Yes 2 12 No	Rican, etc.)	Black, White, etc.
8	hours after turel', or Ite	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 3 ☐ No Specify: Year or Dates:		Specify: White
9	n 72 hours after death with the Marylan "naturel", or Items 23s or 28s-1 show edical Exerciter what he notified at	Completed by	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work)	na 16	6b. Kind of Business/Industry
2 7		ldu	Elementary/Secondary (0-12) College (1-4or 5+)		
2007 1 212	be filed withital Hygiene. d other then	ç	12th Butcher		Esskay
, E	m - 0 5	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name T = 1		aiden Sumame)
14 Va		2		Copper	
NE 14, 2007 4 Maryland 21215-0036	2 2 2 2	(v)	19a. Informant's Name/Relationship (Type, Print) Sister Anna Thornton - Daughter 810 Creek Road Balt		
JUNE .e, Ma	1 end Heelth tsm 27	1			
0.0	0 0 == =		1 ☐ Burial 2 ♥ Cremation 3 ☐ Bernoval from State cemetery, crematory or other place)		Oc. Location - City or Town, State
Ë	Pa in S		4 □Donation 5 □Other (Specify) Bayview Crematory 6-18	3-2007Ba	altimore, Maryland
JU Baltimore,	permit. Deperting imports eny inju				i Funeral Home, P
13.3	707 • d		Foliat Molling 1201 Dundalk Ave		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac c shock, or heart failure. List only one cause on each line.	or respiratory arres	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition a Metastate lung non-small	cell ca	ranoma Months
	/Medical Examiner		resulting in death) Due to (or as a consequence of):		,
	*	L	Sequentially list conditions, b.		
	sit s	ine.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.		
	and I-tran	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):		
760,	te be executed ysicien and e burial-transit	calE	555 to (51 to 2 551 to 4 551).		
87	~ > @				
Box 68	ding se as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
മ	atten for u	clan	in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy		Month Day Year
P.O.	The law requires that the death certifica ate hes been signed by the attending ph page 2 should be detached for use as th	Physician/Medi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		
م م	thet ed by deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
HUBERT Vital Records,	uires the signed to be det	d by		1 ☐ Yes	2 No 3 Probably 4 Unknown
E O	w requir been si should I	ete		24a. Was an	24b. Were autopsy findings available
HUBERT	hes ge 2	Completed		autopsy	prior to completion of cause of death?
UB	n: Ti ficete or, pa	e Co	OF Western through a strict	1 ☐ Yes 24	
₩ N	ysician: The law is certificete hes t director, page 2 s	0	examiner?	h Check only one	
of B	Phy r this	. To	1 mpatient 2 en outpatient 3 DOA 4 Nursing Ho	28d. Describe hov	ice 6 Other (Specify)
KALB	ding th. Afte fune	tlor	27. Manner of Death D⊠ Naturat 5 □ Pending Compared to the pending (Month, Day Year) Di Accident investigation Di Accident investigation Di Accident investigation Di Accident investigation 28a. Date of Injury (Month, Day Year) Di Injury Di Injury Mork? 1 □ Yes 2 □ No		
KALB, Division of	i or Attanding Physeleter death. Director: After this in by the funeral di	Certification:	3 Suicide 6 Could not be 28e, Place of Injury - At home, farm, street, factory, office	28f. Location (Stre	eet and Number or Rural Route Number,
Š	effer Dire	erti	4 Homicide determined building, etc. (Specify)	City or Town,	State)
	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: After this certifical completely filled in by the funeral director, I		29a. Certifier 1 rd Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place,	and due to the cau	use(s) and manner as stated.
	1 24 h	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence)	red at the time, dat	te and place, and due to the cause(s)
_	To th Within To th comp	Me	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Month, Day, Year)
			I meeting Wright MM DS274	0	Tune ISM ZOM
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		
	ł ,		ERNESTINE WRIGHT, M.D. 2300 DULANEY VALLEY ROAD	TIMONI	UM MD 21093
	St	ate	31. Date filed (Month, Day, Year) 32. Restrar's Signature		
	Regist	rar	JUN 1 6 2007 Jacon A Roseles		

DHMH 17 Rev 1/2001

4:20 P.M.

JUNE 14, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. C. 3. Time of Death 7 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** NE 0% /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2□ F Director filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. 3 Widowed 4 Divorced "natural". 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy important: If Item 27 is marked other any Injury or other transments. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service Licensee **D**4 Approximate Interval Between Ouset and Death 23a. Part1. Enter the disease, or som shock, or heart failure. List of lications that caused the deal Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a lonsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-trar Due to (or as a consequence of): Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) the 9∏Unknown as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use co moute to the cause of death? Completed by 2 No 1 Tyes 3 Probably 4 ☐Unknown 4b. Were autopsy findings available prior to completion of cause of death?

1 □ Y ≥ 2 □ No 24a Was an autopsy performed Yes 2 No 1□ Yes 25. Was case referred examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Tyes 2 ER/Outpatient 3 DOA 1 Inpatient Other (Sp. funeral dir 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) 1 Natural
2 ☐ Accident 5 ☐ Pending investigation Injury 1 🗌 Yes 2 🗌 No death. within 24 hours after death To the Funeral Director: 6 ☐ Could not b 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Letifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day Year) 29b. Signature and title of certifier State JUN 1 8 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** $P^{\,\mathsf{M}}$ Grace Longwell June 2007 7:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1870 Quebec Street Severn Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days 1 □ M 2 💢 F New York Director 119-01-3420 98 May 13, 1909 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 No Director MD Anne Arundel Severn 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Examiner must be nonce. U.S.A. 1870 Quebec Street 21144 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White Completed by 3 Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Secretary Utility Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Robinson Abigail Yager ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Bell /son 1870 Quebec Street, Severn, Maryland 21144 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State W. Arundel Crematory June 16, 07 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature | Funeral Service Licenses 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. M00773 1411 Annapolis Road, Odenton, Maryland 21113 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYDCARDIAL **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, Due to (or as a conse juence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Renal Insufficiency 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Mitral Insufficiency autopsy performed? Yes 2X No this certificate Hypertension Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: /
completely filled in by the f 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

10

Registrar

Luis A. Casas, M.D. 31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

JUN 1 8 2007

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D24997

8317 Cherry Lane, Laurel, Maryland 20707

29d. Date signed (Month, Day, Year)

June 15, 2007

07-04473	
01-04413	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Brent Eric- Ogden	1	I- For State	State of	Maryla			tment of <i>ificate of</i>			Ment	al Hy		Reg. No.	20	007	1950
Physiciar Medical Examin	1	Registrar 1. Decedent's Name (First, Bra	Middle,Last)	c Ood	en La	Mer	.				2	2. Date of Dea Month June 11,	ath Day	Year		me of Death 333 hrs
		4a. Facility Name (if not ins Shady Grove Adv	itution, give st	treet and nu		i iCI		b. City,	Town, or L	ocation o	f Death		40	County of D		
Funeral Director		5. Social Security Number 538-98-5683	6. Sex		7. Age (In y			If Und	ler 1 Year	If Unde	r 24Hrs.	1			oreign	
	ŀ	Usual Residence of Decede	nt	2F		32	Yrs.					Nov. 2	29, 1	1974		ngton, DC
nd how any	_ [Maryland Mor	_{unty} Itgomer	'V	10c.	City, T	fown or Locati Ga		ersbui	- 0						Inside City Limits Yes 2 X No
Marylau r 28a-f s	Director	10e. Street and Number 24201 Welsh			1				p Code 2088					ited S	•	
with the ms 23a o		11. Marital Status	_ 1	2. Was Dec		in U.S				anic Orig		cify Yes or N			American Ir	ndian, Black,
ifter death I", or ite	y Funeral	1 Never Married 2 3 Widowed 4	Married 1	1 Yes	2 X	No			2 X No		T dello N	ican, etc.)		Specify:	Whit	ie .
2 hour "natu	Completed by	15. Decedent's Education Elementary/Secondary (highest grad College (1		ed)	16a. Deceden during me Detec	ost of wo	orking life. I				Mar	Kind of Busin cyland oital	Nati	•
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	å	17. Father's Name (First, MWilliam L.	LaMere							Shei	la E	First, Middle, Murr	ay			
MD 2: nd 2 should lith and M m 27 is m:		19a. Informant's Name/Rela Summer L. Lal											urg,	ity or Town, Mary	land	20882
Ore, ges l and t of Heak : If item		20a. Method of Disposition 1 Burial 2 Crer	nation 3	Removal fro	om State	20ь. Р Мот	lace of Dispos ematory or off itgomer ematori	ition (Na	ame of cem	etery,	June 20	Date 17,	20c.	Location - C	ity or Towr	n, State
haltimore, rmit. Pages I a epartment of He nporant: If ite jury or other ti	ŀ	4 Donation 5 Oth 21. Signature of Funeral S.		e			emātori 22. N	um, lame and	d Address	of Facility						ryland 11e, Inc. 10850-280
m ឱក្ខាធិ Physician	10	23a. Part I. Enter the disease	e, or complica	ations that co		019 death.	Do not enter the	Wes	st Mor	itgon such as ca	nery A	Ave. F	rrest, sh	ville, ock, or heart	Ap	0850-2805 proximate Interval etween Onset and
/Medical Examiner		failure. List only one of Immediate Cause (Final dis or condition resulting in de-	ease a.Pu	ulmonary ie to (or as a												Death
	١,	Sequentially list conditions if any, leading to immediate	b	e to (or as a											-	
isi ed (A)	Examine	(Disease or injury that initial events resulting in death)	ted c	e to (or as a	·											
	edical	UNPENDED	d	AMENDED												
	ΣΙ	IF FEMALE: 23b. Was decedent pregnar past 12 months?			oirth nant at time		2 Fe	tal death		Ectopic	c pregnan	су	23	Nonth	elivery Day	Year
O. B. nat the de de by the stached f		Part II. Other significant c		9 Unkno		not re	sulting in the u	ınderlyir	ng cause gi	ven in Pa	art I.				-	ause of death?
ds, P, equires the een signe ould be d	eted by	(1 Y		24b. We	ere autopsy	4 Unknown y findings available
of Vital Records, P.O. ing Physician: The law requires that th After this certificate has been signed by uneral director, page 2 should be detach	Completed						_						opsy formed? 2 1	dea	or to completh? Yes	letion of cause of
lital Rician:	å	25. Was case referred to mexaminer?	Hos	spital:	Innatient	2 🗸	ER/Outpatient	3	26.Place	of Death Other		nly one)	Resid	ence 6	Other:	
n of V ding Phy After th'	일:	1 ✓ Yes 2 No. 27. Manner of Death 1 ✓ Natural 5		28a. Date			28b. Time of I		28c. Injur	_	?			jury occurred		
	Certification	2 Accident 3 Suicide 6	Pending Investigation Could not be determined	28e Plac		- At ho	me, farm, stre	et, factor	L	es 2 uilding, et		28f. Location or Town,		and Number	or R ural R	Route Number, City
Diving the Hospital or within 24 hours after the Funeral Diricompletely filled in	edical Ce		ng Physician I Examiner: O	: To the bes	st of my kno of examinat		e, death occui									Jse(s)
F × × × × × × × × × × × × × × × × × × ×	Me	29b. Signature and title of o		nd manner s	lated.			25	9c. License				- 1	Date signed		Day, Year)
40		30. Name and address of p				,					lat -	MD 645		ne 12, 200		
3 [©] Sta	te	Theodore M. King	Year)	32.	ant Medic gistrar's Si	ignatur	B /	111 F		eet, Ba	uumore	, MD 2120	JT			
Registr	ar	JUN	18 200	U1 / 1/2	BUS.	نار	Boo									

Physician

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

Raymond Joseph Lynch

4a. Facility Name (If not institution, give street and number)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death

June 8,

Month

Day

2007

4c. County of Death

3. Time of Death

1:15A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 8:00 A. 14. MARGARITE ALBERTA 2007 McCANN June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3 Trelawny Court Lutherville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 ☐ M 2 🛛 F 80 Maryland Maryland Director 214-22-0950 1926 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Baltimore Lutherville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A.
Race - American Indian, 3 Trelawny Court Funeral 21093 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 years College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Ferdinand Kiel Owens Anna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John E. McCann (husband) Trelawny Court Lutherville, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) New Cathedral Cemetery 6-18-07 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212 rasse 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4004 **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any many that it immediates cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 poinths?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should be Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1□ Yes 201No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Nursing Home 6 Other (Specify) Certification: To 1 | Yes 2 2 Ne 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Hatural Injury 1 ☐ Yes 2 ☐ No 2 Accident hours after deat uneral Director; filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral F Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 10

DHMH 17 Rev 1/2001

State

Registrar

Name and addr

31. Date filed (Month

Year)

8

who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

1:36A M

10d. Inside City Limits

USA

14. Race - American Indian, Black, White, etc.

Baltimore City

Specify: White

1 Yes 2 XXV

State Registrar Amend 10e, perFH,G869, 7/23/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day. **JOHN** CLARK MITCHELL 2007 /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death
Baltimore Examiner 4b. City, Town, or Location of Death Center Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 29, 1918 6. Sex 9. Birthplace (State or Foreign Days Hours 1**X**M 2□F 160-16-5506 89 Mary and

Yrs

Funeral Director

al or Attending Physician: after death. I Director; After this certifica To the Hospital or within 24 hours af To the Funeral D

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy 2**X** No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 1 -chla 120152 D41410

29d. Date signed (Month, Day, Year) 200

MARYLAND 21204

TOWSON.

23d. Date of delivery

Day

Year

Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOGINDER F. M. D. 7601 OSLER DRIVE

31. Date filed (Month, Day, Year)

Medical

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day MICHIE **Physician** ARTER 10:35A 2007 ULE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALLAGE 10 HAR ROAD 3/12 000 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F 7586 2/734 norg Mrs Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at Yes 2 No BALTIMIE Director (AVY/AM) 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural" ~ " once. U512 21218 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 25 ♣60 If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☐ No ģ 3 Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry, 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Kents Belle Elementary Elementary/Secondary (0-12) College (1-4or 5+) Education TENENER SCHUUL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be - Kuth White 6 ARTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) on pollshow his MICHIE, J. En neth 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 18-07 1 Burial 2 cremation 3 ☐Removal from State OFFERMOUNT COMER 4 □ Donation 5 □ Other (Specify) 22. Name and Address Facility CUATH AN 21. Signature of Pineral Service Licensee ReisTershon Rel Bolhower 12/2/11 on 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. disease or condition resulting in death) atherosclerotic Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown rate has been signed by to page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, p 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 1□ Yes 2□No Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA P After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No Hospital or Attendl 24 hours after death. Funeral Director: A etely filled in by the fu death. 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar asmin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

492

00061480

CAmpbell Blud, Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 7:42 AM Edwin Francis Miller June 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 927 Ellendale Dr. Baltimore Towson If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day. **Funeral** Months Days Hours 1**X** M 2□ F 81 216-20-6717 Yrs. November 14,1925 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified an once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Towson Funeral Director Maryland | Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21286 United States 927 Ellendale Dr. 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Yes, Give Year or Dates: WW II Specify Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) electrical contractor electrical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Higgins William Henry Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Towson, MD 21286 927 Ellendale Dr. Dorothy Jane Miller/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem GardJune 19,2007 Timonium, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility}
Mitchell-Wiedefeld Funeral Home,
6500 York Rd. Baltimore, MD 2 23a, Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart faild Immediate Cause (Final disease or condition resulting in death) failure rcual Chrunic **Physician** /Medical Due to (or as a consequence of): Mellitus Examiner Dia betes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The to for as a consequence of). Examine Coronary Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performe 1 Yes 3 Z No 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated. 29c. License number 5 9 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 15, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) York Pd: Suite 102 10 Doyle 3 Registrar's Signature , Day, Year) State JUN 1 8 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- State of Maryland / Registrar	Certificate of Death	/lental Hygier Reg. I	2007 05
6	Physicia		1. Decedent's Name (First, Middle, Last) HAZEL MILROY		1	Day Year 04:07 A.M.
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$		8. Date of Birth (Month, Pay, Ye. Sept 1, 1	HOWALD 9. Birthplace (State or Foreign Country) 917 Maryland
	yland now at		Usual Residence of Decedent 10a. State	wn or Location		10d. Inside City Limits
	he Mar 18a-f sh otified	Director		Columbia	1.2	1 Yes 2 No
	th with t 23a or 2 ist be n	al Dir	10e. Street and Number 5400 Vantage House Road	10f. Zip Code 21044	10g.	Citizen of What Country? USA
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	within 72 ho iene. than "natur the Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 2	a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Secretary	king	. Kind of Business/Industry
land 2	should be filed ind Mental Hyg is marked other umatic event, t	To Be Co	17. Father's Name (First, Middle, Last) Ernest Peter Francis	18. Mother's Nam	e (First, Middle, Maid sa Davis	den Surname)
, Mary	and 2 shouealth and N n 27 is mar		19a. Informant's Name/Relationship (Type. Print) Matthew Dieubonne/godson 19	9b. Mailing Address (Street and Number or Ru 383 Rustling Leaf Col	ral Route Number, Cit umbia, MD	ty or Town, State, Zip Code) 21045
Baltimore,	Pages 1 annent of He ant: If item ant: or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (\$\overline{Specify}) 20b. Place ceme	of Disposition (Name of tery, crematory or other place)	Date 20c	. Location - City or Town, State
Balt	permit. F Departme Importan any Injur		21. Signature of Edneral Server Served e, Director	State Addrong as Baltimore, MD 2120)1	altimore Street
68760,	Physician and physician and physician and physician and street the purial-transit	al Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do shock, of heart failure. List only one cause on each line. Immediate Ca be (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last	pe of: failure de of:		Approximate Interval Between Onset and Death Clay S Years
P.O. Box 687	eath certif attending for use as	Physician/Medical	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death			23d. Date of delivery Month Day Year
	w requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting hypertension, complete	D 4 1 0 0	23e. Did tobacc	co use contribute to the cause of death? 2
Division or Vital Records,	cate has bei	Completed by	dementra, pleural.	effusion	24a. Was an autopsy performed 1∐ Yes 2	
- Kit	yslcian s certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/	Othor	th (Check only one)	e 6 ⊡Other (Specify)
io uoi	Attending Physician: r death. ector: After this certifics by the funeral director, I			D. Time of lnjury M 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how i	
Divis	i Dir	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	the Hospital hin 24 hours a the Funeral mpletely filled	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowled and manner: On the basis of examination and manner stated.			
	To the within To the complex	Me	29b. Signature and title of certifier MD, FCCP	29c. License number D 36845		Date signed (Month, Day, Year) une 04, 2007
			30. Name and address of person who completed cause of death (Item 23:		annen	, MD, FCCP
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature		470	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death **Physician** June 2, 2007 3:37 PMM Charlotte Maenner /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 349 Homeland Avenue #3A Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 29, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🖾 F 84 Yrs 1923 Director 218-12-4609 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits ul Hygiene. cither then "naturel", or lieme 23a or 28a-1 ehow vent, tre Medical Examinar must be notified at 1€ Yes 2 No MD Baltimore Direct 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 349 Homeland Avenue #3A 21212 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1♥DYes 2□No If Yes, Give Year or Dates: 143-4 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify. 2 43-46 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) administration U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any living or other traumatic event SIDE. Be Charles John Maenner Eva Marguerite Deal ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ellen Maenner/niece 8359 Hillendale Road Baltimore, MD 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ronal 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director frens Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic abstractue lungdiscosse **Physician** /Medical Due to (or as a consequence of): Examiner Signantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed burial-transit Due to (or as a consequence of) Box 68760, ettending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the eld be detected for P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ 1 Yes 2 No 3 Probably 4 Unknown should ! Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No Director: After this certific I in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 - Homicide To the Hospital within 24 hours a To the Funeral Completely filled in Hospital 624 hours at 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 25205 Jun 7, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Chile St, Belto, Md 20201 G Bonc 6701 R. Ley 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryla		artment of <i>rtificate o</i>			giene Reg. No. 2	ů T	101	- 1 A
	Physic	ian	Decedent's Name (First, Middle, Last,)				2. Date of De Month		Year	3. Time of	Death A M
	/Medi Examir	cal	Baby Girl Mira 4a. Facility Name (If not institution, give The Johns Hopk 5. Social Security Number 6. Sec	street and number)	al s. last birthday)	Balt funder 1 Ye	n, or Location of Deat	rity	4c. County of		7.50	
	Funeral Director		none	M 200 F	Yrs.	Months Day		8. Date of Bird (Month, Da June 8,	y, Year) 2007	Gounts 1ary 1	ace (State o. y) and	roreign
	ehow	_	Usual Residence of Decedent 10a. State 10b. County ND Part 4 decedent		City, Town or Lo					100	d. Inside Cit	
	with the M Sa or 28a-f Le notifie	Director	MD Baltimor 10e. Street and Number 324 Townsend Road	e	Esse	X 10f. Zip Code	21221		10g. Citizen of W	/hat Countr	1 ☐ Yes ry?	212110
036	72 hours after death with the Maryland naturel', or items 23a or 28s-1 ehow lical Exacritat must be motified at	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puer	specify Yes or No to Rican, etc.)		- America k, White, et	tc.	
21215-0036	within 72 ho ene. then "natur he Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	DO NOT use ret	ne during most of wo	rking	16b. Kind of Bu	siness/Indu	ustry	
Maryland 2	2 should be filed withir and Mental Hygiene. Ie marked other then aumatic event, the Ms	To Be Co	17. Father's Name (First, Middle, Last) Juanza Marie Mira	one nda	none		18. Mother's Na	ne (First, Middle,	none . Maiden Sumame	9)		unk
	Health tem 27 other tr		19a. Informant's Name/Relationship (Ty Johns Hopkins Hosp 20a. Method of Disposition 1 Burial 2 Cremation 3 DR	Dital 20b	600 1	•	est and Number or Rice Street B.			287		
Baltimore,	permit. Pages Department of Important: If i eny Injury or one		4 □ Donation 5 ☒ Other (Specify) 21. Signature of Funeral Service Licens ROD		or Si	2. Name and Ado tate Ana 11timore	dress of Facility tomy Board MD 2120	d 655 W.	Baltimo	re St	reet	
J.	Physician /Medical Examiner		23a. Part \ Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the de ne cause on each line. EXTYEMO	eath. Do not en				rrest,		Approximate Interval Bets Onset and D	ween
8760,	sate be executed obysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons Due to (or as a cons								
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregna			23d. Date Mon	of deliver	•	/ear
	w requires that been signed b should be deta		Part II. Other significant conditions con TRISOMY 13	ntributing to death but not r	esulting in the u	nderlying cause	given in Part I.	23e. Did t	obacco use contri Yes 2 No	bute to the		leath? Jnknown
of Vital Records,		Completed by						24a. Was autor perfo	osy p ormed? d	rior to com eath?	sy findings a	available ause of
Ĭ.	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital: —			Other	ath (Check only o				
on of	ding Phys	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Ir	4 🗀 Nursing F		dence 6 Othe	1-1-77		
Division	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	t home, farm, st cify)			28f. Location (City or To	Street and Numbe wn, State)	er or Rural	Route Num	ber,
	he Hospil in 24 hour he Funeri pletely fille	Medical (29a. Certifier 1 Certifying Physical Check only one) 2 Medical Exami	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, deat ination and/or in	h occurred at the evestigation, in m	a time, date and place by opinion, death occu	and due to the urred at the time,	cause(s) and man date and place, a	nner as sta and due to t	ited. The cause(s)
)	To 1 To 1	×	29b. Signature and title of certifier	almal	uil.	29c. Lice	onse number	9	29d. Date signed June 8			
			30. Name and address of person who co	empleted cause of death (III	tem 23a) (Type,		Wolfe ST		sitimize			287
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	1.00	0			,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2007 Month **Physician** June 12, 8:21 AM M Louis C. Metzler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 🕅 M 2 🗆 F 92 Maryland Director 212-05-2671 Aug 4, 1914 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Reisterstown 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21136 306 Cantala Court #324 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WW 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: white Completed by WWII 3XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 self employed tanning salons 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Metzler Emma Dorothy Morris ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Metzler/son 16361 Markoe Road monkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation _5 Qther (Specify) 21. Signature of Euneral Service Licensee Ronald S. Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 1. Into the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day in the past 12 months? Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by Derighent Vasculier desembly 2 No 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has all director, page 2: autopsy performed?

Examiner attending physician and for use as the burial-tran been signed by the should be detached

Division or Vital Records, P.O. Box 68760,

NOT

Baltimore, Maryland 21215-0036

LINE 12, Jan 7

		1 Yes 2 No 1 Yes 2 No
25. Was case referred to medical	26. Place of Death	h (Check only one)
examiner? 1 ☐ Yes 2 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor	me 5 ☐ Residence 6 Øther (Specify) NOSP (€
27. Manner of Seath 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
200 Cortifier (Secretifying Dis	purisions. To the heat of my knowledge, death appurred at the time, date and place	and due to the equee(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D 58303 29d. Date signed (Month, Day, Year)

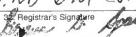
30. Name and address of person who completed cause of death (Item 23a) (Type Print)

AND S. (AHMMB, NO 6701 Charles ST TOWENNO 21204 J. CHAMIRS, NO

State Registrar

Medical

31. Date filed (Month, Day, Year) JUN 1 8 2007



To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

amend Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. 1.2,24a,26 per doc 868 6-18-07 vt. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2 Date of Death 3 Time of Death . Decedent's Name (First, Middle, Last) Day 26 Year Month Nancy Martin **Physician** unkeron 07 /Medical 4b, City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carroll Carroll Lutheran Village Westminster 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min Pennsylvania 1 □ M 2 F Yrs. Director -26 006-22-9797 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Carroll Finksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21048 USA 2820 Patapsco Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White ò 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ school teacher education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item Z7 is marked oth any Injury or other traumatic event once. Be Sidney Breese Dexter Nancy Binney Dunning 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carroll Lutheran Village 1000 Wheller Circle #117 Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature of Funeral Service Licensee Ronald S. Made irector ens 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician interven disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner discore Cormany autery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and the burial-trai Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy signed by the atter in the past 12 months? Year Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 I Inknown 9 Unknowh signed by ٦. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown carculana page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed' this certificate phedema 1□ Yes 2K No Division or Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient Certification: To 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death. 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral D TC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c, License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0038096 Trail Hampstead all) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Northwoods 4231 OLDING 31. Date filed (Month, Day, Year) 32. F State JUN 1 8 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene,

		1	For State Of Maryland		tificate of L			leg. No.	007	195	
	2	_	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day	Year	3. Time of Dea	
	Physicia /Medic	al	Nicholas Richard Em	manuel	Martin 4b. City, Town, or	Location of Death	June 1		nty of Death	10:00	P [™]
	Examin	er	4a. Facility Name (If not institution, give street and number)		•	Rockville			ntgome		
-	Funeral		Shady Grove Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. In	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	1		place (State or Fo intry)	oreign
	Director		None 1⊠M 2□F	Yrs.	WOTHIS Days	10 18	June 10.			yĺand	
	and w	- 1	Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Lo	cation					10d. Inside City L	_imits
	Maryle f sho led at				Germa	ntown				1 □ Yes 2]	⊠ No
	r 28a-	irec	Maryland Montgomery 10e. Street and Number		10f. Zip Code			10g. Citizen			
:	th with	Funeral Director	18858 Bent Willow Circle #928			374			ed Sta		
	tems	nue	11. Marital Status 1. Married 2 ☐ Married 1. Marver Married 2 ☐ Married 1. Marver Married 2 ☐ Married	S. 13.\	Was Decedent of Hi If Yes, specity Cuba	ispanic Origin? (Sp ın, Mexican, Puerto	ecity Yes of No- Rican, etc.)	. 14.	Black, White		
0000	Irs affe	by F	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:				Specify White/			
5	72 hou natura lical E	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work	ing	16b. Kind o	of Business/	ndustry	
Ž	ithin 7 ne. han "i	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. l	None Not use retired	()		Ŋ	None		
7	filed w Hygie ther ti	Ŝ	17. Father's Name (First, Middle, Last)		NOTIE	18. Mother's Nam	e (First, Middle,				
<u> </u>	id be l ental ked o ic eve	To Be	Neil B. Martin			Natal	ie T. B	ullocl	Κ		
ary	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the M-dical Examiner must be notifiled at	-	19a. Informant's Name/Relationship (Type. Print)	1	ng Address (Street						,
χ. Σ	and 2 lealth m 27 i	1	Neil B. Martin/Father		Bent Wil				on - City or		<u> </u>
	ages 1 nt of 1- t: If Ite / or ot		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	emetery, crei ntgomer	osition (Name of matory or other place y um, Inc	June 200		Beth	esda,	Maryland	i
Бапппо	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inmportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once.		21. Signature of Funeral Service Licensee	mätori D ²	Name and Addre			Home	/Rocks	rille. Tr	
ă	permi Depar Impor any ir		MOO1	.98 30	Name and Addre Dert A. O West Mo	nteomery	Ave., Ro	ckvil	le, MI	20830-2	<u> 2805</u>
			23a. Part1. Inter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.		ter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Betwee Onset and De-	eath
	Physician /Medical		Immediate Cause (Final disease or condition resulting In death) a. Due to (or as a consequence)		TYPERT	ENSION	J		_	06/10/2	00.1
	Examiner		Pull month		HYPOPL	ASIA				06/10/2	1007
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		moson	A Ac	A 1 D P D D D	J.ml	(max)	06/10/2	DANC
10	eculted and transi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen		moson	THE MID	NORME	ility	(164)	06 11010	100
68760,	icate be execufted physician and s the burial-transit	al E		1401104 01)							
28	tificate ng phys as the	edical	0.								
X R R	leath certific attending p I for use as	an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Feta	al death 3	⊒Ectopic pregnanc	y		23d	I. Date of de Month		ear
П	the att	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown The past 12 months? 4 □ Pregnant at time of control of the past 12 months? 4 □ Pregnant at time of control of the past 12 months?	death 5[Other (specify)						
л О	w requires that the di been signed by the should be detached		Part II. Other significant conditions contributing to death but not res	sulting in the u	underlying cause giv	ven in Part I.	23e. Did	tobacco use	contribute t	o the cause of dea	ath?
g S	quires n sign	d by	PREMATURITY AT 31	I W	EEKS		10	Yes 2	No 3∏P	robably 4 □Un	ıknown
<u>ဂ</u>	aw rec is bee 2 shou	plete					24a. Was	nsv	prior to	utopsy findings av completion of cau	vailable use of
ř	The lavate has	Completed by					perf 1⊟ Yes	ormed? 2 X No	death? 1 ☐ Ye	s 2 No	
Vita	ician; certific ector,	B	25. Was case referred to medical examiner?	3.ED/O. h	ot other	26. Place of Dea			Other (Se	noifi ()	
ō	Phys r this ral dir	5	27. Manner of Death 28a. Date of Injury	28b. Time	of 28c. Inju		lome 5 ☐ Res 28d. Describe			scily)	
on	nding th. r: Afte e fune	ation	1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury		Yes 2 No					
Division or Vital Records,	ir Atte ter dea irecto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At h building, etc. (Special Could not be building).	nome, farm, s ify)	treet, factory, office		28f. Location City or To	(Street and I own, State)	Number or F	lural Route Numb	ier,
	pital o		29a. Certifier Certifying Physician: To the best of my kn	owledge, dea	ath occurred at the t	time, date and place	e, and due to the	e cause(s) a	nd manner a	ıs stated.	
	To the Hospital or Attending Physician: The law requires that the death certificate be execufted within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	ation and/or	investigation, in my	opinion, death occ	urred at the time	e, date and p	lace, and du	e to the cause(s)	
	To th within To th comp	Me	29b. Signature and little of certifier			se number				nth, Day, Year)	
)			· good,		Dia C	57942		06	110/2	007	
	\		30. Name and address of person who completed cause of death (Ite INEZ V. REEVES, MD, 99) 31. Date filed (Month Pay, Year) 33 Registrar's Sign	m 23a) (Type	EDICAL	CENTER	DR. R	ockvii	UE, 1	1D 2085	50
	, St	ate	31. Date filed (Month Day, Year) 37 Registrar's Sign	nature	and a						
	Regist	rar	OUNT O CHAIL PROGRESS Y	O. Ash							

DHMH 17 Rev 1/2001

BABY BOY MARTIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr., g868,06/18/07dhb

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Wehring 0150aM ber 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Koseda pital Ja Iti more nart 9 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) Date of Birth (Month, Day, **Funeral** March 19, 1**∑** M 2□ F Months Days Hours Director 216 -46-6412 59 ,1948Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 □ Yes 🎞 No Baltimore Essex Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 USA 103 Homberg Avenue 'natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Balto. Co. Schools Custodian 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 is marked of Sebastian Mehring Gay Hanna 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Mehring /wife 103 Homberg Avenue Baltimore MD 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State per it. Pages 1
Department of H
Important: If ite
any injury or ott Holly Hill Cemetery 6/15/07 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Sign of Funeral Service Nicenses Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cadse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Failure Physician 1-W1 minant disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hepatic Mass Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician ar lphaිරය Division or Vital Records, P.O. Box 68760, Physician/Medical attending p ass IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) has been signed by the sign 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No autopsy rector, page 2 performed? To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No No Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) Injury Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident s after death. 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours af To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 31 000 30. Name and address of persoul who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day 13. 2007 1:19F OON /Medical 4c. County of Death
Baltimore (If not institution, give street and number)

Joseph Medical 4b. City, Town, or Location of Death Examiner Center Towson Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 KF 212-20-6796 Yrs. Director 0-19-1916 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☐ No by Funeral Director timore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21239 Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
The marked other than "natural", or flems 23a mark if fleam 27 is marked other than "natural", or flems 23a may or other traumatic event, the Medical Examiner must Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam Be ္ tarmer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Reval Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trai once. bughter) (602 North bowne 20b. Place of Disposition (Name of cemetery, crematory or other place) Balto-MD21239 Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (*Specify*) 3 ☐Removal from State 20/07 Bastimore, MD 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death WEEKS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Immediate Cause (Final RECURRENT ASPIRATION PNEUMONIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner YEARS CEREBRAL VASCULAR ACCIDENT WITH DYSPHAGIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami CANDIDA GLABRATA URINARY TRACT INFECTION sician and burial-tran Due to (or as a consequence of) Box 68760, attending physician for use as the buria Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I signed by the a 9☐Unknown 9 Hunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2XNo 3 Probably 4 Unknown ATRIAL FIBRILLATION 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No DIABETES MELLITUS TYPE TWO page 2 s has perform certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident (Month, Day Year) 5 ☐ Pending investigation s after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled Hospital within 24 hours a Secritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie DØØ63977

State Registrar DRIVE

TOWSON,

MARYLAND

21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARTINA DARULOVA

JUN 16

31. Date filed (Month, Day, Year)

7601

Registrar's Signature

OSLER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year **Physician** MAIE 11:21 June 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 218-22-6145 1 M 2 2 Director 5.6 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ms 23a or 28a-f shor 1 Pres 2 No Director TIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.5.A 21213 Funeral ortant: If item 27 is marked other than "natural", or items Injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Menone. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ပ 19a Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3906 INNERCOLO 10. Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages ' 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State 21. Signature of Fyneral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23d. Date of delivery 3 ☐Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 2 No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate t 1 Yes 2 director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 🔲 Yes 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

5

30. Name and address of pe

31. Date filed (Month, Day, Year)

8

known as Maggie

DHMH 17 Rev 1/2001

who completed cause of death (Item 23a) (Type, Print)

32. Rajistrar's Signature

			1 - For State Registrar		(Cert	ificate of L	Death		Re	g. No.		
	·**		Decedent's Name (First, Middle, La	st)						Date of Death	h Day	Vear	3. Time of Death
	Physici /Medio		NANCY NORTON						J	Month UNE	Day 2	2007	5:40 A M
	Examir		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, or	Location o	of Death		4c. Cour	nty of Death	
			STELLA MARIS				TIMONIUM				BAI	TIMOR	
	Funeral Director		519-26-3333	ex 7. Age (I ☐ M 2 1 F	n yrs. last birth	rs.	If Under 1 Year Months Days	If Under a	Min.	Date of Birth (Month, Day, ept 9,			place (State or Foreign ntry) inia
and	*		Usual Residence of Decedent 10a. State 10b. County	10	0c. City, Town	or Loca	ation					1	10d. Inside City Limits
Maryl	f eho	5	MD Baltim	ore	То	wso	n						1 ☐ Yes 2√ No
a	28a	rec	10e. Street and Number				10f. Zip Code			10	0g. Citizen o	of What Cou	ntry?
- Time	38.0	Funeral Director	500 Virginia Ave	nue #803				21204	ŀ			USA	
deat		ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. W	as Decedent of Hi Yes, specify Cuba	ispanic Orig	gin? (Specify	y Yes or No-		ace - Ameri	
within 72 hours after death with the Maryland	Deportment of Health and Mental Hyglene. Important: If Item 27 Ie marked other than "natural; or Iteme 23a or 28a-f show styl hjury or other traumatic event, Itie Mudical Examiner must be nuffilled at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			☐ Yes 2🌠 No	Specify:		.,		^{cify:} whit	
2 P	natu	etec	15. Decedent's E (Specify only highest gra	ducation ade completed)		Give k	ent's Usual Occupa	during most	t of working		16b. Kind of	Business/Ir	ndustry
ithin A	Pan.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			O NOT use retired						
y pe	her t		12 17. Father's Name (First, Middle, Last	3	lic	ens	sed pract	ical	nurse	irst, Middle, A	healt	theare	
d be fill	od of	Be.	Claude Madison								naioon oun.	21107	
hould	d Me mark matic	2	19a. Informant's Name/Relationship (19b.	Mailing	Address (Street		Le Sch		City or Tow	vn. State. Zi	p Code)
2 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	Ith an	1	Sandra Linden/dau	,, ,			Faraday						016
5 - G	Item othe		20a. Method of Disposition		20b. Place of	Disposi	the second secon	I	Date		20c. Locatio		
0 8 E	nt: F		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 🛣 Donation 5 ☐ Other (Special Control of Con		Cometery	, 0181112	atory or other plac	6)		1			
DallIIIIOI permit. Peges	Depertm Imports any Inju once.		21. Signature of Funeral Serve Lince		tor		Name and Address			55 W.	Balti	more S	Street
			20a. Part 1. Enter the disease, or com	plications that caused th	e death. Do no		Ltimore, rthe mode of dyin		21201 cardiac or re	espiratory arre	est,		Approximate
Div			shock, of heart failure. List only Immediate Cause (Final	one cause on each line.			Bren	2					Interval Between Onset and Death
	ysician Medical		disease or condition resulting in death)	a. Due to (or as a c			/3 / 6 1 .						6 m 0
Ex	aminer	_			orisequence o	17.							
		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	onsequencs o	f):						-	
cuted	nd ransit	Examiner	ii arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c									
exe O	en er rrial-t		resulting in death) Last	Due to (or as a c	consequence o	t):							
OX OO/OU,	physicien end s the burial-transit	Medical		d	-								
Brtific	On 168	Me	IF FEMALE:	00. 1/		0.2	3777 P. 3						
death	been signed by the ettendin should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 { 4 Pregnant at time 9 Unknown	Fetal death		Ectopic pregnancy Other (specify)					Date of deliv Month	rery Day Year
Ords, P.O	deta	y P	Part II. Other significant conditions	contributing to death but r	not resulting in	the und	derlying cause giv	en in Part I.		23e. Did tob	oacco use co	ontribute to	the cause of death?
Sering	n sign	d by								1 □ Ye	s 2 🖪 No	3 ☐ Pro	bably 4 □Unknown
	s bee	Completed								24a. Was a	n 24	b. Were aut	opsy findings available ompletion of cause of
The law	certificete hes t irector, page 2 s	E								autops perform 1 ☐ Yes 2	med?	prior to co death? 1 Yes	
	tifice tor. p	0	25. Was case referred to medical					26. Place	of Death (C	Check only on		10 103	20110
lysici	direc	To B	examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Out	patient	3□ DOA Oth	өг. 4 С Nu	rsing Home	5 Reside	ence 6 🗆 0	Other (Spec	ify)
ان الله الله الله الله الله الله الله ال	within 24 hours effer death. To the Funerel Director: Affer this certific completely filled in by the funeral director.		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	'ear) 28b. Ti	ime of	28c. Injur Wor			d. Describe ho	ow injury occ	curred	
S S	tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be					Yes 2		1 (0)			
OIVISION lor Attending	Direc Direc in by	ertification:	4 Homicide determined		- At home, far (Specify)	m, stre	et, factory, office		281	City or Town	reet and ivu	mber or Hui	ral Route Number,
spital	nerel filled	O	29a. Certifier 1D Certifying P	l nysician: To the best of r	my knowledda.	Juath	occurred at the tin	na date an	d stace, and	due to the m	ouse(s) and	толлыг ая	stated
Ho:	n 24 F.	edical		miner: On the basis of ex and manner state	camination and								
Toth	withir To th comp	×	29b. Signature and title of certifier				29c. Licens		0 3	2	9d. Date sig	/	Day, Year)
			Pora 3	· Man	MY		03	28	0 4		6/1	12/	7007
			30. Name and address of person who ROBERT MOSS, M.					TIMO	NIUM,	MD 23	1093	ion:	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUN 1 8 20	32. Registrar's	s Signature	box	le le						

DHMH 17 Rev 1/2001

The law requires that the death certificate be executed Records, P.O. NETTLES **EVELYN** Division or Vital Hospital or Attending Physician:

Box 68760,

ttending physician

death with the Maryland

Maryland 21215-0036

Baltimore,

2007

r 28a-f show notified at

a or

"natural", or Items 23a dical Examiner must b

certificate After this death. after death in by the To the Hospital within 24 hours a To the Funeral I 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 oistrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 8 Registrar **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #1 Per Phy G869 7/06/09er#ficate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Petersen Month Dav Year 11:00 a M 2007 June 13 Edward 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince Georges Heart Fields Assisted Living @ Bowie Bowie If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 1**™** M 2□F 88 Oct. 13, 1918 Louisana 439-14-6121 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ¥Yes 2 ☐ No Laurel Prince Georges Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20708 U.S.A. 14117 Dub Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2 ∐No If **Y**es, Give Year or Dates:1943**-**1946 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White 3 ™Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Government Position Management Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Crane Joseph S. Peterson, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10003 Goose Pond Court Laurel, MD 20708 Christine Holmes/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 6/14/2007 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Nan Fleck Funeral Home 7601 Sandy Spring Road Laurel, MD 20707 2 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ACCIDENT CEREBROVASCULAR disease or condition resulting in death) Due to (or es a consequence of) Sequentially list conditions, have been good to in a class cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? ALZHETMERS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 Ⅳ No 24a. Was an autopsy perform 2 1 No 2 No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Aursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 Yes 2 No 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury

Physician /Medical Examiner be executed and Box 68760. physician P.O. ned by Division or Vital Records,

Attending

burial-tran the use as attending p for use as detached funeral director, After To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

P

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 9a....any lipiny or other traumatic event, the Media...

Physician/Medical 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical examiner? Be မ 27. Manner of Death Certification: 1 Watural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 1 Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D24997

State Registrar 31. Date filed (Month, Day, Year)

LUIS

CASAS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) O8 Month Physician PASTINE JUNE 11:50PM. DONALD JOHN 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOWARD COLUMBIA HOWARD COUNTY GENERAL HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 1 ₹ M 2 □ F Jan 31, 71 1936 Pennsylvania Director 579-44-8837 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√∑ No Prince George's Director MD Laurel 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 10617 Glen Hannah Drive 20723 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white þ 3 ☐ Widowed 4 X Divorced 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 physicist ENIG Associates 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Pastine Marie Russell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Jessica Putzier/daughter 802 Huntersway Bozeman, Montana 59718 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 XDonation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. lart1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Kestiratory **Physician** /Medical Due to (or as a consequence of); Examiner lumon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Vear in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a 9☐Unknown 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1.X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ▼ No 24a. Was an autopsy performed? 2)X(No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

P.0. Division or Vital Records, To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera

Baltimore, Maryland 21215-0036

Box 68760.

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier (Check only one)

> Drive JUN 1 8 2007

, MD, FCCP

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAI-CHI NGUYEN, MD, 73.50 Cara ce Drive Colymbra, MD 21044 Colin 32 Registrar's Signature

ORIGINAL

29c. License number

D36845

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day **Physician** May 23, 2:00 PM M 2007 Luther Earl Prichard /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 5610 York Road #209 Baltimore Birthplace (State or Foreign Country)
 Ohio If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 21, 5. Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□F Months Days Hours Yrs 62 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 √ Yes 2 No Director MD Baltiore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21212 5610 YOrk Road #209 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel unk unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Luther Oliver Prichard Emily Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 171 Seagull Drive Pasadena, MD 21122 Betty Feeheley/niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 MOther (Specify) in state 21. Signature of Funera Service Licensee Ronald S. Wade, State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD Approximate Interval Between Onset and Death 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate dause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury Examine inding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. Physician/Medical ettending I for use as 23c. ficome of pregnancy birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No birth Month Year Pregnant at time of death 5 Other (specify) sete hes been signed by the e page 2 should be deteched to 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the undertying cause given in Part I. β 1 Yes 2 No 3 Probably Dnknown Completed 24a. Was an autopsy performed?
1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificete To the Hospital or Attending Physician: ieral Director; After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 2X100 Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funeral Direct completely filled in by 4 - Homicide 29a. Certifier The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer as stated.

The dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and the of certifier death (Item 23a) (Type, Print) strar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 Month **Physician** 21:28PM KOSE 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner alh Sina Hospital 0 Baltinge mare If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 F Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene.

Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No MD. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2120 15 Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 No 1 ☐ Yes 2 If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (nown NOUL ဥ 19a. Informant's Name/Relationship mber, City or Town, State, Zip Coll e. Print) 19b. Mailing Address (Street and Number or Rural Route Nu 20a. Method of Disposition Pages 1 5 Important: If It any Injury or o 1 Burial 2 □ Cremation 3 □Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease shock, or heart failure. L on clications that caused the death one cause on each line. as cardiac or respiratory arrest Immediate Cause (Final Physician hemotana ay disease or condition resulting in death) /Medical Examiner 41 Cine Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and the death certificate be execu P.O. Box 68760. Due to (or as a consequence of) as the burialattending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) ☐Yes 2☐No been signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 250 No this certificate 2 No 1 TYes 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, p. 25. Was case referred to medical examiner?
1 → Yes 2 □ No 26. Place of Death (Check only one) Be Other: 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 2 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Natural (Month, Day Injury 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10Males 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M GENUN INM HOSPITT 1 HOWAS 32. Pajistrar's Signature 31. Date filed (Month, Day, Year)* State Registrar JUN 1 8 2007

DHMH 17 Rev 1/2001

			For State Registrar	State of N	laryland / Dep Ce	artment <i>rtificate</i>					giene Reg. No	200	7 19521
	Physic	ian	1. Decedent's Name (First, Middle, L	•						2. Date of De Month	ath Da	ayYear	3. Time of Death
-	/Medi	cal	Josephine C. Ros		-1	4b Cib. T		Location o	of Dooth	June 1		2007 Year	4:10A M
	Exami	ner	4a. Facility Name (If not institution, gi Stella Maris	ve street and numbe	r)	Timo			oi Death		1	altimore	
	Funeral Director		214-01-9105	Sex 1 □ M 2 □ F 7.4	Age (In yrs. last birthday 91 Yrs.		1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 5/7/19	th ly, Year	9. Bir Co Ma	thplace (State or Foreign ountry) aryland
	/land ow at		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation							10d. Inside City Limits
	e Man ta-f sh	Director	MD Baltim	ore	Baltimor	9							1 □ Yes 2 🔀 No
	with the	Dire	10e. Street and Number	7 1 5 11	4	10f. Zip (itizen of What Co	ountry?
	ns 234 must	Funeral	8100 Rossville B	12. Was Deceder		212 Was Decede		spanic Ori	igin? (Spe	ecify Yes or No		SA 14. Race - Ame	erican Indian,
920	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ont, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ፟ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	₫ No	If Yes, speci 1 ☐ Yes 2		n', Mexicar Specify:		ecify Yes or No Rican, etc.)		Black, White Specify: White Specify:	e, etc. nite
5-0	72 ho 'natur dical I	eted	15. Decedent's E (Specify only highest go	Education rade completed)	16a. Dece (Give	edent's Usual kind of work DO NOT use	Occupa k done d	ation during mos	t of worki	ng	16b. k	Kind of Business	Industry
121	within lene. than he Me	Completed	Elementary/Secondary (0-12)	College (1-4o	r5+) l	<i>bo not use</i> Manufa				-	 Fa	ctory Wo	orker
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Co	17. Father's Name (First, Middle, Las Frank Fontanazza	t)				18. Mothe		(First, Middle e Tagli	, Maidei	n Surname)	
lary	2 shou and M is mai		19a. Informant's Name/Relationship	,								or Town, State,	
e, ≥	1 and Health em 27 ther tr		Frank A. Rossi /	Husband	20b. Place of Disp	ROSSV		BIA		m. 114		timore, ocation - City or	MD 21236
Baltimore,	t. Pages rtment of I rtant: If its		1 X Burial 2 □ Cremation 3 [4 □ Donation 5 □ Other (<i>Spec</i>	ify)	Parkwood	Cemet	herplace e ry	6	/16/	2007	Bal	timore,	Maryland
Bal	permi Depar Impo any Ir		21. Signature of Juperal Sewice Like	W.S.	1 1	2. Name and eonard			•	5305 Balt،	Hai imo	rford Ro re. Marv	oad /land 21214
	Dhysisian		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	y one cause on each	ed the death. Do not en line.								Approximate Interval Between Onset and Death
	/Medical	П	disease or condition resulting in death)	a. ALZHEI Due to (or a	MER'S as a consequence of):								
	Examiner	-	Sequentially list conditions,	b. Due to (or a	as a consequence of):								
Np.	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events	c	u 001100quo1100 017.								
8760,5	be e ician buria	cal Exa	resulting in death) Last		as a consequence of):			•		-			
9	ntificate ng phys s as the	Medi	IF FEMALE:										
O. Box	Attending Physician: The law requires that the death certific death. ector: Atter this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal death 3 at time of death 5	⊒Ectopic pre ⊒ Other (spe						23d. Date of de Month	livery Day Year
σ.	s that the ned by detac		Part II. Other significant conditions	contributing to death	but not resulting in the	ınderlying ca	use give	en in Part I.		23e. Did t	obacco	use contribute to	the cause of death?
ords	equires en sign ould be	ed by								10	Yes 2	2 □ No 3 □ P	robably 4X Unknown
Division or Vital Records, P.O.	The law re ate has be page 2 sho	Completed								24a. Was auto perfo 1 Yes	psy ormed?	prior to death?	utopsy findings available completion of cause of
Vita	Iclan: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Toub			(Check only o	one)		
o	Phys rr this eral dir	-: To	1 ☐ Yes 2 ▼ No 27. Manner of Death	28a. Date of Ir	njury 28b. Time o			4 □ Nu		me 5 Resi			cify) HOSPICE
ion	inding ath. r: Atte e fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, L	Day Year) Injury	М	3c. Injury Work 1 □ \	k?ື` Yes 2 □ I		200. 2000.	novi inju	ny dodaned	
Divis	al or Atte s after des il Directo	Certification:	3 ☐ Suicide 6 ☐ Could not le 4 ☐ Homicide determined	Zoe. Place of t	njury - At home, farm, st etc. <i>(Specify)</i>	reet, factory,	office		-	28f. Location (City or To			ural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate hat completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the beaminer: On the basis and manner	st of my knowledge, dea of examination and/or instated.	th occurred anvestigation,	it the tim	ne, date an pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s date ar	s) and manner as nd place, and du	s stated. e to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier			1 4		13)	2 i	_	29d. Da	ate signed (Mont	
	5		30. Name and address of person who	completed cause of	death (Item 23a) (Type			1 3 /	4 1			1. 1	/ /
			DR. TARIQ MAHMO		DULANEY VAL	LEY RD	. :	TIMON	IUM,	MD 210	93		
	Sta Regist		31. Date filed (Month, Day, Year) JUN 1 8 20	07 Jesus	strar's Signature	de							

DHMH 17 Rev 1/2001

JUNE 14, 2007 4:10 a.m.

JOSEPHINE ROSSI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 7:15 Virginia P. Rees 2007 AM June 14, 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Carriage Hill Bethesda Bethesda Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Year) Months Days Hours 1 ☐ M 2 🖾 F 98 085-05-0717 April 9, 1909 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location 1 ☐ Yes 2 No Chevy Chase Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20815 United States 4207 Rosemary Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alice Jacobs Arthur Erph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4207 Rosemary Street, Chevy Chase, Marland 20815 Don Peterson / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium Inc. Date 20c. Location - City or Town, State 20a. Method of Disposition June 15, 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2007 22. Name and Address of Facility Robert A. Bethesda-Chevy Chase Inc. Bethesda, Maryland 20814 Pumphrey Funeral Home/ 7557 Wisconsin Avenue 21. Signature of Funeral Service Licenses M01433

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic every "..."

/Medical

10a. State

Director

Funeral

þ

Completed

Be

ပ

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit ď within 24 hours a

To the Funeral I

completely filled

Division or Vital Records, P.O. Box 68760,

	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the death. Do not enter th one cause on each line.	ne mode of dying, such as cardiac o	r respiratory arrest,	Interval Between Onset and Death						
	Immediate Cause (Final disease or condition	Pneumonia			Oliset and Death						
	resulting in death)	Due to (or as a consequence of):									
		Dysphagia									
ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):									
Ē	Cause (Disease or injury that initiated events	Dementia									
Exa	resulting in death) Last	Due to (or as a consequence of):									
ia Sal		L _d .									
edic											
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		topic pregnancy her (specify)	2	3d. Date of delivery Month Day Year						
ed by Pr	Part II. Other significant conditions of	contributing to death but not resulting in the under	rlying cause given in Part I.		se contribute to the cause of death? ☑ No 3 ☐ Probably 4 ☐Unknown						
Somplete				24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No						
Be	25. Was case referred to medical		26. Place of Death	(Check only one)							
	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing Ho	me 5 Residence 6	B □Other (Specify)						
Medical Certification: To	27. Manner of Death 1 ⊠ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how injury							
Sertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		factory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,)						
dical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best of my knowledge, death oc miner: On the basis of examination and/or invest and manner stated.	ccurred at the time, date and place, tigation, in my opinion, death occur	and due to the cause(s) red at the time, date and	and manner as stated. place, and due to the cause(s)						
Ž	29h. Signature and title of certifier	0 11	29c. License number	29d. Date	e signed (Month, Day, Year)						

20

29c. License number

D35579

29d. Date signed (Month, Day, Year) June 14, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6844 Tulip Hill Terrace, Bethesda, Maryland 20816 Susan J. Miller, M.D.

31. Date filed (Mp) State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	State of Maryland / De State of Maryland / De	epartment of Hea Certificate of Dea			ene . _{No.} 2 0 1	17 1952	3			
P	Dhi.ai	R	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	3. Time of Death				
	Physicia /Medic		Alice Michelle Stafford				4, 200	7 9:30 P	М			
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Loca			4c. County of					
ž.			Oaklodge Assisted Living 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Pasadena	Under 24 Hrs.	8. Date of Birth		Arunde1 Birthplace (State or Fore)	ian			
	Funeral Director		220-56-2227 1 M 2 M F 55 Yrs	Months Days He	ours Min.	08/27/1	. 951	9. Birthplace (State or Forei Country) MD	3			
.K	D		Usual Residence of Decedent									
	arylar show	ř	10a. State 10b. County 10c. City, Town o					10d. Inside City Limi				
	the M 28a-f ootifie	ecto	MD Anne Arundel Glen 10e. Street and Number	Burnie 10f. Zip Code		100	J. Citizen of Wh		\dashv			
	with sa or	١	14 Georgia Avenue	21061			U.S.					
	ms 2:	Funeral Director		13. Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Spe	cify Yes or No-	14. Race	American Indian,	\neg			
00	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hylgiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 Never Married 2 Married I Yes 2 Married I Yes 2 Married I Yes 2 Married I Yes, Give Year or Dates:		pecify:	nican, etc.)	Specify:	White, etc. White				
-0003	2 hour atura cal Ex	ed	15 Decedent's Education 16a De	ecedent's Usual Occupation	1	16	 6b. Kind of Busi	ness/Industry				
ה ה	hin 72 an "na Media	Completed	(Specify only highest grade completed) (C	Rive kind of work done during te. DO NOT use retired)	ng most of workir	ng						
7	ygiene gertha ertha	Com	10 Но	memaker_			own Ho					
2	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)			(First, Middle, Ma						
2	I 2 should be filed within h and Mental Hygiene. I is marked other than iraumatic event, the Me	ပို	Simon Wilbur Gillespie			Romair						
2	d 2 sh th and 7 is n traun			lailing Address (Street and I Georgia Av			•					
ָם ע	f Heal tem 2 other	. 1	20a Method of Disposition 20b. Place of D	isposition (Name of				ity or Town, State				
2	Pages ent of ht: If i		1 Burgal 2 XICremation 3 Hemoval from State	crematory or other place) w Cremator	v 06/1	8/07 E	Baltim	ore, MD				
Dallillo	mit. partmoortai		21. Signature Septice Live see					al Home, P.	A			
Ď	an De		Mille	169 Rivier	a Driv	e, Pasa	dena,	MD 21122	1			
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or fleart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a unsequence of):	9	uch as cardiac o	r respiratory arres	t,	Approximate Interval Between Onset and Death Onset Approximate Sylvariant				
30 / 00 / H	ate be executed hysician and the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
.O. DOX 0	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ 100 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify)								
colds, r	quires that n signed b ıld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in	Part I.	23e. Did toba	_	oute to the cause of death? B Probably 4 Unknown				
ב	sician: The law requir s certificate has been si irector, page 2 should I	Completed				24a. Was an autopsy performe	ed? pri	ere autopsy findings availal or to completion of cause c ath? Yes 2 2 No	ble			
ומו	ertifica ctor, l	Be C	25. Was case referred to medical examiner?	26.	. Place of Death	(Check only one)		Arc do 1h				
5	Physic this or al dire	10	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa			me 5 Residen			1			
	ding F	ion:	27. Manno Death 28a. Date of Injury 28b. Tim	ry Work?	2 □ No	28d. Describe how	injury occurre	· -				
DIVISIO	Attender death	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)			28f. Location (Stre City or Town,		or Rural Route Number,				
	To the Hospital or within 24 hours afte To the Funeral Dil completely filled in	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, conduction on the basis of examination and/one and manner stated.	or investigation, in my opinio	on, death occurr	ed at the time, dat	te and place, ar	nd due to the cause(s)				
•	To Writh	2	29b. Signature and Moof pertifier All 1	29c. License nui	094	290	0/15/	(Month, Day, Year)				
	<i>'</i> }		30. Name and address of person who completed cause of death (Ifem 23d) (Ty	1 Muellon	Hank	Orwe,	Clen !	Borne, and, 21	106)			
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	4					/			

State

31. Date filed (Month, Day, Year) JUN 1 8 2007 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				State of Ivia	i yiaiiu /	Certific		Death		g. No.	7	19529
	• • • • •		1. Decedent's Name (First, Middle, Las	t)					Date of Death Month	Day `	Year	3. Time of Death
	Physici /Medic		Lois L. Sears						May 31,	2007		7:30 PM
-	Examin		4a Facility Neme (If not institution, give					4b. City, Town, or Lo	cetion of Death	4c. County o		
2			North Hampton Ma	anor Nursi	ng Cen			Frederick		Frede		
ı	Funeral Director		219-44-4002	9x 7. Age □M 2∏ F	(In yrs. last b	Yrs. If U	nder 1 Year oths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 30,	Year) 1947	9. Birthpl Coun Mary	ace <i>(State or Foreign</i> try) 1and
21215-0020	DC &		Usual Residence of Decedent 10a. State 10b. County		10c City Toy	wn or Location	<u> </u>		 -		10	0d. Inside City Limits
	e Maryla Sa-f sho	ctor	MD Frederic	k	,,	nitsbur	g					1 ☐ Yes 2√ No
	with the	Funeral Director	10e. Street and Number 17331 North Seto	n Awanua		101	f. Zip Code	21727	10	og. Citizen of WI	nat Coun USA	try?
	ns 23	era	11. Marital Status	12. Was Decedent E	ver in U,S.	13. Was D	ecedent of F	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race	- Americ	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: if item 27 is merked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be indified at ance.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	o		specify Cub es 2🏋 No	an, Mexican, Puerto Specify:	Rican, etc.)	Specify:	, White, wh	ite
Ž	2 ho	Be Completed	15. Decedent's Ed		166	a. Decedent's	Usual Occup	pation	ina	16b. Kind of Bus	iness/Inc	dustry
Ž	e. Bro "n	g.	(Specify only highest gra-	College (1-4or 5+)		(Give kind of work dor life. DO NOT use reti		d)	"'g	7 41		
7	er th	ő	12	0		secre	etary			librar		
ב	d off	Be	17. Father's Name (First, Middle, Last) 18.						18. Mother's Name (First, Middle, Maiden Sumame)			
Maryland	hould d Men merks metic	P P	Gilbert Vernon F 19a. Informant's Name/Relationship (7)		19	h Mailing Ado	dress /Street	Reginal Rand Number or Run	a Mary L:		State, Zip	Code)
<u>s</u>	d2s than 7 is r	ĺ	Gilbert Eiker Ji					Ridge Roa				
	Heal Heal tem 2		20a. Method of Disposition	, brother	20b. Place	of Disposition ery, crematory	(Name of			20c. Location - C		
Baltimore,	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specify		Cemen	ery, crematory	or other pra					
Rail	permit. Departr Imports any inji		21. Signature Funer Service Licen Runald S.	Wade, Dire	ector		e Anat imore	ess of Facility Comy Board MD 2120		Baltimo	ore S	Street
	Physician	П	23a. Part1. Enter the disease or compensation of heart failure. List only	plications that caused	the death. Do					est,		Approximate Interval Between
			23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Onset and Death
	Wedical Examiner		Immediate Cause (Final disease or condition as METASTATIC BREAST CANCE resulting in death)							MA	9	BARS
H	Lxammer	<u>.</u>	resulting in death) Due to (or as a consequence of):									
	uted d ansit	Examiner		b	Tue to for as a	to (or as a consequence of):						
o,	tificate be executed g physician and as the burial-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying								i	
68760,	te be ysicia ne bu	edlcai	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
		Med	d.									
Вох	attend attend for us	Physiclan/M										
P. O.	the g	ysic	Part II. Other significent conditions of	ontributing to death bu	t not resulting	in the underly	ring cause gi	ven in Part I.	23b. Did tobacco use contribute to the ceuse 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐			
	that the ded by detac								1 U Y	98 213 NO	3 LI Pro	bably 4 Officiow
Records,	law requires that the death cer ras been signed by the attendir s 2 should be detached for use	Completed by							24a. Was a perforr	n autopsy ned?	av	ere autopsy findings allable prior to mpletion of cause
ဋ	e lav has je 2	ם		-					4ED V	057/11-		déath?
	icien: The k certificate ha rector, page									es 2 No		∃Yes 2□No
Vita		Be	25. Was case referred to medical examiner?	Hospital:		2	DOA Ot	her: 4 Nursing H	th (Check only on		r (Specil	50)
ō	Physoral dis	7	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatie 28a. Date of Injur (Month, Day	-	. Time of	DOA 28c. Inju		28d. Describe ho			<i>,</i>
o	ding th. After	to	1 Natural 5 ☐ Pending		Year)	Injury M		Work? 1 □ Yes 2 □ No				
Division of	or Attending Physicien: after death. Director: Atter this certific in by the funeral director,	Certification:	2 Accident 3 Suicide 4 Homicide 1 Homicide 1 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						ce 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.	edical Ce	29a. Certifier (Check only one)	ysiclen: To the best on niner: On the basis of and manner sta	examination a	ge, death occu and/or investig	urred at the ti ation, in my	ime, date and place, opinion, death occur	and due to the cared at the time, d	ause(s) and mar ate and place, a	nner as s ind due t	tated. o the cause(s)
	ithin (Med	29b. Signature and title of pertifier	and mariner sta			29c. Licen	se number	2	9d. Date signed	(Month,	Day, Year)
	5 7 £ 7		1/1///	MC 1	10		1)6	26499		6-7	-0	7
			30. Name and address of person who	completed cause of de	eath (Item 23e) (Type, Print)	700	• /		,		
			Ronald E. Miller					Center	Mt. Air	v MD 21	771	
	Sta		31. Date filed (Month, Day, Year)	32, Redistra	r's Signature	! Son	Sel Sing	g Center	iive filt.	,,	_,,_	
	Registi	rar	11IN 1 8	2007	ucs 1	1						

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	State of Maryland			t of Health a e <i>of Death</i>	and Me		_ 6U	07	195	30
			Registrar 1. Decedent's Name (First, Middle, Last)		Cert	iiicati	o Death	12	P. Date of Dea	leg. No.		3. Time of [Death
Н	Physicia	an	1. Decedent's Name (First, Middle, East)	diene F					Month	Day	Year		Ам
	/Medic	al -	Donne.	اللاالدا		4h Cihi	Town, or Location o	f Dooth	06	O COUR	ty of Death		- (
1	Examin		4a. Facility Name (If not institution, give str	eet and number)	19	40. City,	1111	Death		40. 00011	y or bourn		
			Blue Point NSQ 25	7. Age (In yrs. las	10 FUC	If Under	1 Year If Under	24 Hrs. 8	B. Date of Birtl	2	9 Rinthr	place (State or	Foreign
	Funeral		5. Social Security Number 6. Sex	v 2□F 81	Yrs.	Months	Days Hours	Min.	(Month, Day	(, Year)	Cour		unk
	Director		430-38-6036	01				J	Tan 20,	1920	1		
	A =		10a. State 10b. County	10c. City,	Town or Loc	ation					1	Od. Inside City	Limits
	Mary feh	ŏ	MD Wicomico	Fr	uitlan	ıd						1 Tes	2K No
,	within 72 hours after death with the Maryland ene. Than 'natural', or Iteme 23a or 28a-f ehow the Madical Examiner moust be multified at	Funeral Director	10e. Street and Number			10f. Zip	Code			10g. Citizen of	What Cou	ntry?	
	Sa or	0	200 S. Camden Avenu	10			2	1826		т	JSA		
	leath ne 2:	era		2. Was Decedent Ever in U.S.	13. W	/as Dece	ent of Hispanic Orig	gin? (Speci	ify Yes or No-	14. Ra	ce - Ameri		
	fler fler	교	1 X Never Married 2 ☐ Married	Armed Forces? 1 □Yes 2 X No		_	city Cuban, Mexican	i, Puerto Ri	ican, etc.)		ack, White,		
ဗ္ဗ	urs a	Ď	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give ** Year or Dates:	1	☐Yes	2 No Specify:			Spec	<i>⊪y:</i> Wh	ite	
Ò	2 ho	ted	15. Decedent's Educa (Specify only highest grade		16a. Decede	ent's Usua	al Occupation	t of working	unk	16b. Kind of	Business/In	dustry	unk
2	hin 7	pje	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT u	se retired)		'				
7	gien d	Completed	unk un	k			· · · · · · · · · · · · · · · · · · ·						1.
g	e filed al Hygie other vant, E	Be (17. Father's Name (First, Middle, Last)			ι	ink 18. Mothe	er's Name (First, Middle,	Maiden Suma	ime)		unk
<u>a</u>	uld b Went	2											
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. If Health and Mental Hygiene 'ratural', or Iteme 23a or 28a-f ehow fitten 27 ie marked other than 'ratural', or Iteme 23a or 28a-f ehow other traumatic evant, the Medical Examinar must be notified at		19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailing	g Address	(Street and Number	er or Rural	Route Numbe	r, City or Tow	n, State, Zij	Code)	
Σ	and 2 saith n 27 er tr	1	Blue Point Nursing				elvedere		-			212 <u>15</u>	
Baltimore,	permit. Pages 1 and 2 Department of Health a important: if item 27 is any injury or other trai		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rea	cen	ce of Dispos netery, crem	sition (Nai atory or c	ne of ther place)	Da	te	20c. Location	1 - City or T	own, State	
Ĕ	Pag nent nnt: fr		4 Donation 5 Dother (Specify)				i						
<u>=</u>	partn ports y inju		21. Signature of Funeral Sevice Licensee ROT3 K S . Wa	ade director	22. S	Name ar	Anatomy	Board	655 W	. Balti	more	Street	
m m	88 2 2 8		xmm1/1	1 1010-			ore, MĎ	21201					
	Cate be executed physician and /Medical Examiner: transit the burial-transit		23a. Patt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									ween	
,			Immediate Cause (Final disease of condition as CARDIOMYOPATHY										
7			resulting in death) Due to (or as a consequence of):										
			Due to (or as a consequence of): CONGESTIVE HEART Failure										
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):										
		Examiner	Cause (Disease or injury that initiated events										
ó	an ar	EX	resulting in death) Last	Due to (or as a conseque	ence of):								
8760,	te be lysici	Physician/Medical	d.										
89	tifica ng ph as th	Med	15 5 CALAD 5						-				
Вох	endii r use	N/u	23b. was decedent pregnant	c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetel of		Ectopic p	regnancy				Date of deliv Month		rear
<u> </u>	dea death	Sicient	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of dea 9☐Unknown		Other (s	pecify)				VIOLILI	Juy ,	041
P. 0.	at the by th	بأر	9 Unknown						60 5:44				
S,	The law requires that the death certific site has been signed by the atlending p page 2 should be detached for use as	b											
ğ	w require been si should l	ed							10	Yes 2□No	3 Pro	bably 4 134	Inknown
သို့	awre is be	plet							24a. Was autor		. Were aut	opsy findings ompletion of c	available ause ol
Vital Records,	The i	Completed							perfo	rmed?	death? 1 ☐ Yes	2 7 No	
	an: rtifica tor, p	0	25. Was case referred to medical				26. Place	e of Death	(Check only o	one)			
>	Attending Physician: r death. sctor: After this certific by the funeral director.	To B	examiner?	spital: 1 Inpatient 2 E	R/Outpatient	t 3 🗆 D	DA Other: 4 Nu	ursing Hom	ne 5□Resi	dence 6 🗆 0	ther (Spec	ify)	
٥	ng Ph ter th heral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury at Work?	21	8d. Describe	how injury occ	urred		
<u>0</u>	ath. r: Af	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(,,	,,	М	1 Yes 2	No					
	ar de by th	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	eet, factor	y, office	2	81. Location (City or To	Street and Nu	mber or Rui	ral Route Num	ber,
	rs afte	Certification:				~							
	Nospitel or Attent 24 hours after death Funaral Diractor: etely filled in by the		29a. Certifier Certifying Physical Check only 2 Medical Examin	ician: To the best of my know er: On the basis of examination	ledge, death on and/or inv	occurred	at the time, date an	nd place, ar ath occurre	nd due to the	cause(s) and date and place	manner as e, and due	stated. to the cause(s	i)
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funaral Diractor: After this certificate has completely filled in by the funeral director, page 2	Medical	one)	and manner stated.	<u> </u>	X				29d. Date sig			
	Twitter Son	2	29b. Signature and title of certifier	n D A), ,	1 13	c. License number	115	20	Zau. Date Sig	I SU (MONITO	, Day, 1801)	
•			Horas	T 12-6	سلامت		2	160	70	ا صا	1	0	
			30. Name and address of person who cor		23a) (Type,	Print)	(14		3	0	1	>10	_
			01/1/K	DRV H	حار	H	2 %	474			<u> </u>	1 - 1 -	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ADB4	2							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** June 4, 8:45 AM M 2007 Floyd C. Shockley /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Salisbury 341 Carey Avenue If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) July 29, 1926 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F 80 Yrs. 218-20-5432 Director Usuel Residence of Decedent Peges 1 and 2 should be tilled within 72 hours after death with the Maryland ment of Heelth and Mental Hygiene.

ent: If item 27 is marked other then "naturel", or items 23s or 28s-f ehow ury or other treumatic event, the Madical Examiner right the published at 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2√ No MD Wicomico Salisbury Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 341 Carey Avenue 21804 USA 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) salesperson life insurance 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Poston Shockley Dorothy Etta Willey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Margaret Shockley/spouse 341 Carey Avenue Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Peges 1 Depertment of H Importent: If ite eny injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑Donation 5 ☐ Other (Specify) 21. Signature of Funefal Service Licensee

Ronald S. Wade, Director

Ronald S. Wade, Director

State Anatomy Board 655 W.

Baltimore, MD 21201

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) ACUTO 8 days **Physician** /Medical Due to (or as a consequence of) Examiner 13 mos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine METASTATIC WIDE SPRIBAD or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetat death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Wells JILS 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Alvdentel 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes W No 1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No ၉ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) o the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Buldade 6/11/07 Helen DOO 1684 1 m. 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) SAUSBURY UND 21801 RIVERSIDE 32 Registrar's Signature 31. Date filed (Month, Day, Year)
JUN 1 8 2007 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 1255 PM atherine laylor 15 June 2007 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Bayvies Medical Center Johns Hopkins Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2X F 87 226-24-1712 November 2,1919 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes 2 ☐XNo Maryland Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 745 Villager Circle 21222 **USA** 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Housewife Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Davis Rosa Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Luke Taylor 745 Village Circle, Dundalk, MD. 21222 son 20b. Place of Disposition (Name of cemetery, crematory or other place) June 19, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore City, MD. Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 Intracerebral Hemorihage Due to (or as a consequence of): Stroke Oue to (or as a consequence of) Due to (or as a consequence of):

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

Directo

Funeral

þ

Completed

Be

2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatte event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

the death certificate be executed sician and burial-trans physician as the b attending p for use as ned by the a e detached f The law requires that sign d be

P.O. Box 68760,

Division or Vital Records,

Hospital or Attending

page 2 has certificate this death.

Examine Physician/Medical Completed by Be Certification: To neral Director: / / filled in by the f Funeral within 24 hours

23a. Part1. Enter the disease of complications that caused the death. In not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to increase asset in the Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ANo Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an autopsy performed? 1∐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

the

2

0

State

DR. Ami K. Mankod, Johnstophius Bayries Medical Ctr. 4940 Eastern Avenue, Baltimere MD 21224

K. Mankodi, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Registrar's Signature

182/18-1

31. Date filed (Morth, May, Year)

RES-000

June 15, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year TERRELL 10.20 AM CLAIRE 2007 UNE 13 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) CITY BALTIMORE THE JOHNS HOPKINS HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 7, 1931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 □ M 2 🛛 F 76 577-38-8026 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2√☐ No Anne Arundel Crownsville 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1224 Severnview Drive 21032 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 XMarried 1 ☐ Yes 2**X** No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unl 16b. Kind of Business/Industry un 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alexander Masaros Mary Secretar 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Forrest Terrell/spouse 1224 Severnview Drive Crownsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 Other (Specify) 21. Signature of Funeral Ser S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director 26a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate cuse (Final disease or condition resulting in death) INTRACRANIAL HEMORPHAGE LO Hours Due to (or as a consequence of): MULTIFORME GLIOBLASTOMA MONTH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? res 2 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner death certificate be executed

Examine y physician and is the burial-transit

as

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

ms 23a or 3 must be n

'natural', or items 23a dical Examiner must I

the Medical

72 hours after death with

should be filed within 7 and Mental Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event, once.

Baltimore, Maryland 21215-0036

Director

Funeral

ģ

Completed

MD

edical

- 1	Σ
	Physician/
	by
	Completed
	Be (
	2
	ation:

Certific

Medical

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and little of certifier

P.O. Box 68760 ed by the a detached f Division or Vital Records, page 2 should certificate this funeral After t To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After filled in by the

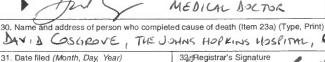
Sta	ite
Registr	ar

DAVID COSCIROVE, THE JOHNS HOPKINS HOSPITM, 600 NORTH WOLFE STREET, BALTIMORE, MD 21287 31. Date filed (Month, Day, Year)

5 Pending

investigation

6 ☐ Could not be determined



28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

D 064931

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

JUNE, 13, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Maryland	•	rtificate of I			Jiene Reg. No. 🤈 🧻	7	10531	
	Physicia		1. Decedent's Name (First, Middle, Last)		rarif	f, Sr.		2. Date of Dea Month June		2007	3. Time of Death 2:43P.M	
	/Medic Examin	al .	Michael Anth 4a. Facility Name (If not institution, give s		rgrii		Location of Death	Julie	4c. County		Z:43F.	
	LAGIIIII		Bayview Medical	Center		Balti			n/			
ļu.	Funeral Director		5. Social Security Number 216-62-3398 0. Septimber 6. Septimber 12	7. Age (In yrs. I	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day May 8,	1956	9. Birthpl Count Mary	ace (State or Foreign trx) Land	
036	yland how at		10a. State 10b. County	10c. City	, Town or Lo	cation				10	Od. Inside City Limits	
	ne Mar 8a-fs	ctor	Md. Baltin	ore E	astwo	T			40. 00.		1 ☐ Yes 2X No	
	with the	Öğr	10e. Street and Number 7239 Gough Stre	at		10f. Zip Code 2122	2/1		10g. Citizen of U.S.A		try?	
	death ms 23	Funeral Director		12. Was Decedent Ever in U. Armed Forces?	S. 13.		ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-		ce - America		
	sfiled within 72 hours after death with the Maryland II Hygiene. other than "natural", or items 23a or 28a-f show rent, the Medical Examiner must be notifled at		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ██No If Yes, Give Year or Dates:	1	1 ☐ Yes 2 🔯 No		ricali, etc.)	Specif		White	
15-0	n 72 h "natu edical	Completed by	15. Decedent's Edu (Specify only highest grad		16a. Deced (Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of work f)	ing	16b. Kind of B	usiness/Ind	lustry	
212		ошо	Elementary/Secondary (0-12)	College (1-4or 5+)		Roofer	,		Coast	al R	Roofing	
nd	0 0 0	Be	17. Father's Name (First, Middle, Last)	c c			18. Mother's Name	, , , , , , , , , , , , , , , , , , , ,		me)		
<u> </u>	d 2 should be filed th and Mental Hygi 7 Is marked other traumatic event, t	P	Harry Vandergri 19a. Informant's Name/Relationship (Ty		19h Mailir	on Address (Street	Doris and Number or Run			State Zin	Code)	
_ ⊠	d 2 s thar 7 Is trau	1	Michael A. Vano	lergriff, Jr.	7239	Gough	Street	Baltim	nore, 1	/d. 2	21224	
Baltimore, Maryland 21215-0036			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval mom State	dens	osition (Name of matory or other place of Fait	:h 6-18			ore,	Maryland	
Balti	permit. Pages Department of Important: If II any Injury or once.		21. Signature of Funeral Service Licens	I I							Home, PA 1. 21222	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Approximate Interval Between Onset and Death 15 Invition (or as a consequence of):									
	ficate be executed g physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Unter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence. Due to (or as a consequence)								
68760,	rificate be executed ig physician and as the burial-transit	edical E	C	d								
Box	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	у		23d. Date of delivery Month Day Year			
ds, P.	juires that i n signed by ild be deta	by	Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.				ne cause of death?	
Recor	Physician: The iaw requir this certificate has been si al director, page 2 should i	Completed						24a. Was auto perfo 1∐ Yes	an 24b psy prmed?	. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of	
Vita	Iclan: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		Lou	26. Place of Dea					
o	Attending Physician: r death. ector: After this certifice by the funeral director, p	2	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatie 28b. Time o	W 90100X	4 Li Nui Sing m	ome 5 ☐ Resi 28d. Describe	dence 6 00 how injury occu	<u>`</u>	(y)	
Division or Vital Records, P.O.	ath. arr. Afte	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		rk? Yes 2∐No	_				
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	Medical (ysician: To the best of my kno iner: On the basis of examina and manner stated.								
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens			29d. Date sign	ed (Month,	Day, Year)	
)	T		> h ruley s	tall physicism	- 00cl (F	D197			6/13/0	7		
(Q		30. Name and address of person who of MILNAIL PURIEL	Tr/8VML 4	11 23a) (Type	Altery,	RVR BAL	TIMORE	nd 2	1224	1	
	Sta Regist		30. Name and address of person who of MILMAILL PURIEL 1 31. Date filed (Month, Day, Year) JUN 1 6 2	32. gistrar's Sign	ature	(m)						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 155 AM 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HAURE (JRACE NURSING Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number
218-28-3626 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🔀 F Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No r 28a-f sh notified Hoingdon Director Maryland Dartor 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or Items 23a or edical Examiner must be r filed within 72 hours after death with 21009 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces 2

1 Yes 2 No If Yes, Girle Was Decedent of Hispanic Ongin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 □ Yes 220No Baltimore, Maryland 21215-0036 Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 7 is marked other than "natu trau⊓atic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private Homes Engineer 2nd Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1105es =//a Watters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Important: If item 27 is any injury or other traconce. Aberdeen, MJ 21001 Department of Health Watter 404 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Marylane 21. Signature of Figneral Service Licensee Fusical His 21206 arvo Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in such line. Immediate Cause (Final dration WK Physician disease or condition resulting in death) /Medical Due to (or as a construence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has I 1∐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: within 24 hours after death.

To the Funeral Director: After Hospital or Attending 24 hours after death. 1 Natural 2 Accident Injury 5 Pending investigation 1 ∏ Yes 2 ∏ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) ပ္ 32600 6 Wynam 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1106 Revalution St. Milliam TD avneDr

Registrar

31. Date filed (Month,

1 8

3. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3:30 p M 2, JOSEPH AUSTIN June 2Q07 DERYCK /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's 15th Avenue, #206 Hyattsville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** Year) Hours Months -Days Min. 1**X** M 2□ F 732-03-3178 61 09/12/1945 Guyana Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a. State ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XX Yes 2 □ No Directo Maryland Prince George's Hyattsville 10g. Citizen of What Country? 10e. Street and Number 7981 15th Avenue, #206 20783 Guyana r death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 ☐ Never Married 2 Married Afro-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced Year or Dates American Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 h (Give kind of work done during most of working life. DO NOT use retired) Federal Management Elementary/Secondary (0-12) College (1-4or 5+) Security Officer ages 1 and 2 should be filed wi ent of Health and Mental Hygier It: If item 27 Is marked other th y or other traumatic event, the 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph S. Beckles Joyce Austin ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7981 Cheryl M. Austin - Wife 15th Avenue, #206, Hyattsville, MD 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 XBurial 2 ☐ Cremation 3 XRemoval from State 4 □ Donation 5 □ Other (Specify) La Repenter Cemetery 6/11/2007 Georgetown, Guyana 22. Name and Address of Facility 21. Signature of Funeral Service License 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Approximate Interval Between Onset and Death 23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immedia Cause (Final disease r condition resulting in death) Myeloma Physician /Medical Due to (o as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner the death certificate be executed that initiated events resulting in death) Last and burial-trai Due to (or as a consequence of): Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) P.O. I ☐Yes 2☐No 9 Unknown The law requires that been signed be should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an s certificate has the inector, page 2 s autopsy perform 1 Yes 2 X No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3/1 No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 27. Manner of reath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 1- Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide determined Hospital or within 24 hours a

To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0064983

31. Date filed (Month, Day, Year JUN 0 5 2007 State Registrar

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)
Kashif Alam Firozui, MD, 2101 Medical Park Dr., #200 Silver Spring, MD 32. Registrar's Signature

20902

Physician /Medical Examiner		1. Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
		Charles Jonatha	an Brooks				Month May	30 Day	2007	1:00 P
		a. Facility Name (If not institution, give s 2000 Arbor Hill La			4b. City, Town, or Bo	Location of Death		i	County of Deatl Prince	George's
Funeral Director	5	777-70-9103	M 2□ F 7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da March 1	v. Year)	9. Birtl Co. Ma	nplace (State or Fore untry) ryland
f show led at		Usual Residence of Decedent 10a. State 10b. County MD Prince Ge		, Town or Lo						10d. Inside City Lim
3a or 28a-f sl st be notified	al Direct	10e. Street and Number 2000 Arbor Hill La	ne		10f. Zip Code 20716	5		-	en of What Co	untry?
	2	11. Marital Status 1 □ Never Married 2⊠ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ∐Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of Hi f Yes, specify Cuba I □ Yes 2⊠ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		4. Race - Ame Black, White Specify:	
iene. than "natur the Medical E	Completed	15. Decedent's Educ (Specify only highest grade	Completed) College (1-4or 5+)	(Give life, L	lent's Usual Occupa kind of work done o DO NOT use retired DUSE Manas	luring most of worl)	king		nd of Business/ Foods	Industry
Hygie other t		17. Father's Name (First, Middle, Last)		11.01.01.0		18. Mother's Nam	ne (First, Middle	, Maiden	Surname)	
Mental arked o atic eve	To Be	Cortez Brooks				Doro	othy Win	ifrey		
PEE	Н	19a. Informant's Name/Relationship (<i>Typ</i> Deborah A. Mehlman/		19b. Mailir	g Address <i>(Street a</i> 2000 Arbo					
0		20a. Method of Disposition 1 □ Burial 2 ፟	emoval from State		sition (Name of natory or other plac in Crematory	o6/(Date D2 / 2007		ndria,	Town, State Virginia
Department Important: Important: any Injury o	1	21. Signature of Fundal Service License	5 170137	_	asch's Fu	ss of Facility		4	739 Bal	timore Av 1e, MD 20
hysician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the deat le cause on each line. METASTA	h. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,	SCER	Approximate Interval Between Onset and Death
Medical xaminer		resulting in death) Sequentially list conditions,	Due to (or as a conseq							(2 years 10
physician and sthe burial-transit	al Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq						1	
attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome pf pregn: 1 □Live birth 2 □ Feta 4 □ Pregnant at time of c	Ideath 3	□Ectopic pregnancy □ Other (specify)	/		2	23d. Date of de Month	livery Day Year
n signed by the all be detached in	2	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.		tobacco u Yes 2[o the cause of death robably 4 □Unkn
	Completed						24a. Was auto perf 1□ Yes	s an opsy ormed? 2,21No	prior to death?	utopsy findings avail completion of cause s 2 □ No
ertifi ector	Be	25. Was case referred to medical examiner?	Hospital:		ot all post Oth	26. Place of Dea				
After th funeral	on: To	27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injur	4 U Nursing F	dome 524Res 28d. Describe			ecity)
ifter deat Director in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, st fy)			28f. Location City or To	(Street an own, State	nd Number or R	lural Route Number,
within 24 hours at To the Funeral completely filled	Medical C	29a. Certifier 1. Certifying Phy (Check only one) 1. Medical Exami	sician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, dea ation and/or in	th occurred at the time timestigation, in my o	me, date and plac opinion, death occ	e, and due to the urred at the time	e cause(s) e, date and) and manner a d place, and du	is stated. le to the cause(s)
To th comp	Me	29b. Signature and title of certifier			29c. Licens D 50	e number 686		29d. Da	te signed (Mon	th, Day, Year)
3		30. Name and address of person who co	ompleted cause of death (Item AHABLA, SUITEM 32. Registrar's Sign	m 23a) (Type	Print) , 651	o Kenili	worlh A	ve. R	IV EROAU	e, Mb

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** TAWANDA DENISE BROOKS May 30 2007 1021 /Medical 4c. County of Death Facility Name (If not igstitution, give street and number) 4b. City, Town, or Location of Death Examiner DALISBURY MEDICAL ENTER Wicomico If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 😿 F MARYLAND Director 213-90-2016 APRIL 19, 1962 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 28a-f show 1 X Yes 2 □ No Director **CHARLES** LAPLATA MD10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ō must be 6195 STARVIEW PLACE 20646 UNITED STATES 23a Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? r than "natural", or items the Medical Exa⊡lner m 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Iten any injury or other traumatic event, the Medical Examinar Black, White, etc. Never Married 2 Mamied 1 ☐ Yes ② No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) TEACHERS AIDE EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM F. PROCTOR MARY LOUISE BROOKS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7530 ABBINGTON DR., OXON HILL, MARYLAND 20745 CHYERELLE COUNTISS/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) SACRED HEART CH. CEM. 06/05/07 LAPLATA, MARYLAND 21. Synature of Funeral Service Ligarises J. J. I. A. I. A. L. THORNTON JOHNSON THORNTONS FUNERAL HOME, PA 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician INTRACRANIAL HEMORRHAGE HONKS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 100 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No page 2 s autopsy funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Limpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

le Funeral Director: A
bletely filled in by the fi 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Hos within 24 ho To the Fun completely The entitying Physician: 10 the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and minimal as saled. (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year)

SIETZANA 31. Date filed (Month, Day, Year)

1415 SOUTH DIVISION SMITE B SALISBURY MD 21804 GULTERREZ 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

D0062916

30,

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2007 JUNE **Physician** 3 MAYNARD LEE BURDETTE, 9:00 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner GOLDEN LIVING CENTER FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) DEC 16 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 □ F Months Yrs. 214-30-1003 74 Director MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show r then "natural", or iteme 23a or 28a-f sho the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No MONTGOMERY BOYDS Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 17000 DARNESTOWN ROAD 20841 USA death Funera 12. Was Decedent Ever in U.S. Armed Forces?

1 Types 2 No 1 9 5 3 - If Yes, Give 1 0 6 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1961 WHITE Š 3 ☐ Widowed 4 ☐ Divorced leted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Compl College (1-4or 5+) Elementary/Secondary (0-12) CARPENTER CONSTRUCTION 10 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other treumatic event 90sg. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (MELVIN RUSSELL BURDETTE, SR. MILDRED MARIE COVELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) MAYNARD BURDETTE, JR. / SON 17681 KOHLHOSS RD., POOLESVILLE, MD 20837 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MONOCACY CEMETERY 6/5/07 BEALLSVILLE, MD 21. Signature of Juny al Prvice Ucens 22. Name and Address of Facility HILTON FUNERAL HOME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20838 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician rebra /Medical Due to (or as a consequence of) Examiner ai Dre Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 10 24a. Was an autopsy performed? 2 1 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 Yes 2 140 Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural Injury 5 Pending To the needs after death.
Within 24 hours after death.
To the Funerel Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide the Hospitel 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

State

Box 68760

P.0.

Division of Vital Records,

House Ave.

Frederick

M

mb 814 32. Resistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kazmi

JUN 0 5 2007

IMM).

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amended#4c per MD #7 per FH Certificate of Death FCHD 6/5/0999. No. 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) 8.30AM **Physician** MAY 2007 /Medical 4c. County of Dea 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Spring Silver Sunrise 1 Jontgomery Bedford Ct by If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Security Number 6. Sex **Funeral** Days 1 □ M 2 1 F USA 255-52-2342 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f ahow other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Maryland Silver Spring Montgomery Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20906 3700 International Drive Items 23a Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after I □Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married white 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 ö Specify: Specify: 3 Widowed 4 □ Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jennie Williams Felix O. Cox 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20906 Pages 1 and 2 s ment of Health an 3915 Isbell Street, Silver Spring, Maryland Department of Health a Important: If item 27 is any injury or other tra Jennie Keating - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Frederick, Maryland Stauffer Crematory 4 Donation 5 Other (Specify) 21. Signatore of Funeral Servic Accensee 22. Name and Address of Facility Stauffer Funeral Home 21621 Opossumtown Pike, Frederick, Maryland 21702 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MIMILE Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Phyalcian: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Box 68760, for use as IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2[1] NO 1 Tes 1□ Yes 20 Be 25. Was case referred to edical examiner? 26. Place of Death (Check onl. one Other: Hospital: 3□ DOA 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 2 1 Yes / 2 100 27. Manny of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: After Injury 5 Pending investigation 1 🗌 Yes 2 No after death. 2 🗀 Accident Director: in by the 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 Suicide determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the the 29d. Date signed (Month, Day, Year) 29b. Signature of certifier 0 completed cause of death (Item 23a) (Type, Print)

Registrar

State

International

2007

07-04412
Joyce Brown

yce Brown		State of Maryland / Department of Hea	Ith and Mental Hy	ygiene	6.	0 / 1954
Amondo	1 De	For state #8, FH, TCHD, 06/13/07 Pha	ırı	Reg. No 2. Date of Death).	3. Time of Death
Physician	/ 1.	Decedent's Name (1 list, Micolo, 2001)	raion	Month Day June 9, 2007	Year	0605 hrs
edical Examine		a. Facility Name (if not institution, give street and number) 4b. City,	Town, or Location of Death		4c. County of Death	1
	4	Talbot Co. Detention Center East	ion		Talbot	
Funeral	5	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Un	der 1 Year If Under 24Hrs	$\neg \bigcirc \square$	M/DD/YYYY) 9. Bir - 1957 Foreig	thplace (State or
Director		216-66-4102 1 M 2XF 49 Yrs. Mon	ths Days Hours Min	88-04	2007 Cd	ountry) Md
	0	Isual Residence of Decedent				Table In the Otto Limite
any		0a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 XYes 2 No
nd thow	ر ا پ	Md. Tulbot Easton		54		
arylar	읈	0e. Street and Number 10f. Z	ip Code	10g. C	citizen of What Cou	intry?
the M a or 2	Director	7/7 South Street	21601		USA	- Dissi
with the Maryland ms 23a or 28a-f show any: be notified at once.	<u>e</u> 1	Armed Forces? If Yes, spe	dent of Hispanic Origin? (S cify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
death	Funeral	1 Never Married 2 Married 1 Yes 2 No			Specify: 12	look
after al", o	by -	or Dates:	2 No specify: al Occupation (Give kind of	work done	o. Kind of Business	/Industry
natur	힣	during most of v	vorking life. DO NOT use re			
n 72 l	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) Deta	iler		Car	wash
5-0036 led within 7 Hygiene. I other than	E-	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Maid	en Surname)	14.
215- be filed ntal Hyg rked of	اه	Willand Nixon	Almo	Virgi	nia Y	Vilson
21215-0036 uld be filed within 72 hours afte Mental Hygiene. marked other than "natural", ie event, the Medical Examiner	To B	19a. Informant's Name/Relationship (Type, Print)	ess (Street and Number or	Rural Route Number	, City or Town, Sta	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		Ida Y. Ositely Sister 526Al		Apt &	oc. Location - City	MJ.2/80/
e, N I and Health item		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, ce)			
Baltimore, permit Pages I an Department of He Important: If ite		1 Burial 2 Cremation 3 Removal from State	ematory 6	6-18-07	Dover,	Delaware
litin nit P artme ortan		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name a	and Address of Fa lility	uneral H	0100 E	
Balti permit Departin Importi	Ţ,	M name 1 1 1496	DAVER St.	EGSTAA	md. 2/	Approximate Interval
Physician	1	29a. Part I. Enter the disease, or complications that caused the death. Do not enter the mor failure. List only one cause of each line.	de of dying, such as cardiac	or respiratory arrest,	snock, or near	Between Onset and Death
Medica	- 1	Immediate Cause (Final disease a Complications of alcohol and	narcotic withdr	wal		Death
xaminer	- 1	or condition resulting in death) Due to (or as a consequence of):				
1		Sequentially list conditions, Due to (or as a consequence of):				
	ië	dause. Enter Underlying Cause (Disease or injury that initiated				1
P is	Examiner	events resulting in death) Last Due to (or as a consequence of):				
executed ian and ial - transit		d.				
be c be c sicial	edical	X UNPENDED #55.7II.27.perME.g869, 724/	07 TT		23d. Date of deliv	very
Box 6876(e death certificate the attending phy ed for use as the b	51	IF FEMALE: 23b. Was decedent pregnant in the 25c. If yes, outcome or pregnancy 1 Live birth 2 Fetal de	ath 3 Ectopic pres	gnancy	Month	Day Year
x 68 h certi tendiin use a	icia	past 12 months? 4 Pregnant at time of death 5 Other (Specify)			
Bo e deat the at	Physici	1 Yes 2 No 9 V Unknown g Unknown	lying cause given in Part I	23e. Did toba	acco use contribute	e to the cause of death?
ires that the designed by the signed by the	by P	Part II. Other significant conditions contributing to death but not resulting in the under		1 Yes		Probably 4 V Unknown
s, P	pe pe	Hepatitis, liver cirrhosis, hypertension, annu	ılar		24b. Were	e autopsy findings available
rds v requ s beer	olet	calcification of mitral valve and coronary ath	erosclerosis	autopsy perform	prior	
ecc he lav ate ha	Completed			1 ✓ Yes 2		Yes 2 No
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Eunoral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	Be C	25. Was case referred to medical	26.Place of Death (Che		esidence 6 🗸 O	Wher Soons
Vita nysici this c	0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	DON		ow injury occurred	ther. Scene
of ng Pł After unera	n: T	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	1 Yes 2 No	20d. Describe ne	,,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
ion tendi tor:	읉	l silvers		29f Location (St	reet and Number o	r Rural Route Number, City
VIS or At fifter d Direct in by) E	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, la	ctory, office building, etc.	or Town, Sta	ate)	
Dipital ours :	Certification:	4 Homicide determined (Specify)	A LL - time - data and place	and due to the cause	(s) and manner as	stated.
e Hos n 24 h e Fur Jetely		29a. Certifier (Check only one) 2 ✓ Medical Examiner: On the basis of examination and/or investigation,	at the time, date and prace, in my opinion, death occurr	ed at the time, date a	nd place, and due	to the cause(s)
To th within To th	Medical	and manner stated.	29c. License number			(Month, Day, Year)
	2	29b. Signature and title of certifier	O.C.M.E.		June 10, 200	7
		Carres C				
		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Stre	et, Baltimore, MD 21	201		
		Alia Nabio IVID. Troticiani IVI				
Regis	itate stra	3 2007 A				
DHMH 17 Rev 1/		ORIGINAL		OCI	ME	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Marguerite Russell Baker June 2007 18:20 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17 Race Street North East
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 TF Director 216**-**05-7848 87 May 20, 1920 Maryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at Yes 2□No Maryland Ceci1 Directo North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or items 23a 17 Race Street 21901 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 V No Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No þ Specify: Specify: 3 ₩idowed 4 Divorced White "neturei", Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) Colfege (1-4or 5+) Tavern Owner Restaurant 9 marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hyg Important: If item 27 is marked other any njury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Thomas Russell Mary Boulden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine M. Kempski/Niece 1171 Appleton Road, Elkton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State June 1 □Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Bay View Cemetery 6, 2007 North East, Maryland 21. Signature of Funeral Service Lices 22. Name and Address of Facility Crouch Funeral Home SDC. 127 South Main Street, North East, Maryland21901 Approximate 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nset and Death Immediate Cause (Final disease or condition **Physician** Dementia /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE 980 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 99 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛍 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

1 Yes 2 No certificate 1 Yes or Attending Physicien: 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death | Check only one Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ŧ ٢ 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of fnjury 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) after 4 | Homicide within 24 hours a To the Funeral L 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical å 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0023322 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Earline Frances Brown 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CAMBRIDGE DORCHESTER DORCH GENERAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Days Hours 1 □ M 2√□XF 85 141-01-1059 Dec. 20, 1921 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1√Yes 2 No Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 West End Avenue United States 21613 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes AGNo Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Continental Can Co. Assembly Line 11 Graduated 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin A. Brown Maude Cornish 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leona M. Brown (Daughter) 205 W. End Ave., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Murial 2 ☐Cremation 3 ☐Removal from State Faith Community Cem. 06/09/07 4 ☐ Donation 5 ☐ Other (Specify) East New Market. MD 22. Name and Address of Facility Framptom Funeral Home, P.A. e of Funeral Service Licenses Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to for each consequence officause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery

Physician /Medical Examiner

Department of Important: If It any injury or conce.

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be re-

Pages 1 and 2 should be filed within 72 hours after

Maryland 21215-0036

Baltimore,

Director

Funeral

Completed by

Be

Examiner

Completed by Physician/Medical

Be

Medical Certification: To

MD

and use as the burial-tran signed by the a page 2 should certificate After

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

after death

within 24 hours a

Division or Vital Records, P.O. Box 68760,

in the past 12 months? 1 □ Yes 2 □ ✓ o 9 □ Unknown		oic pregnancy or (specify)	Month Day Year
Part II. Other significant conditions co	ntributing to death but not resulting in the underlyi	ing cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Reel: Hy	El Collenana Zestinsean	<u> </u>	24a. Was an autopsy performed 2 1
25. Was case referred to medical \(\begin{aligned} \frac{\fir}{\fir}}}}}}}{\frac{\f		26. Place of Dea	ath (Check only one)
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3[□ DOA Other: 4 □ Nursing H	Iome 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 11X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, street, fa building, etc. (Specify)	ctory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
			e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)

29c. License number

D0063359

29d. Date signed (Month, Day, Year)

STREET, CAMBRIDGE, MD-21613

State Registrar

MAHBUBA 31. Date filed (Month, Day, Year,

29b. Signature and title of certifier

JUN O 7

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

,503 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 31 per wichd/6-5-07/dls Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0605 0 Bobby O. Banks /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Charlotte Hall Veterans Home Charlotte Hall If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 6. Sex 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 X M 2 ☐ F Director 227-28-8483 76 Virginia July 10, 1930 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30938 Carico Road U.S.A. Funeral 21875 12. Was Decedent Ever in U.S. Armed Forces? 1 XXYes 2 No 1948 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1948-1 ☐ Yes 2 1 No Specify: Specify: white þ 3 N Widowed 4 □ Divorced Year or Dates: 1952 Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed, 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator 12 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown 0 Maude Lowe 19a. Informant's Name/Relationship (Type, Print) (Step) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other training 2006. Lisa A. McCourry (Daughter) 30938 Carico Rd. Delmar, MD 21875 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Crematory of Delmarva May 31, 2007 Delmar, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home eule 13 East Grove Street Delmar, DE 19940 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cades on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequen

Physician /Medical **Examiner**

The law requires that the death certificate be executed

the

à signed

certificate

within 24 hours a...

7 To the Funeral Dir

icai

Medi

Hospital or Attending Physician:

To the I

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

28a-f show

ö

or Items 23a

natural',

than

other

and Mental F

Hygiene.

event, the Medical Examiner must be notified at

Physician/Medical Completed by

attending physician and for use as the burial-tran page 2 s Be ٩ After thi funeral Certification: I Director: / d in by the f

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner?

examiner?

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signature and title of

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d, Date of delivery Month

Year Day

23e. Did tobacco use contribute to the cause of death? 4 Unknown

1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an

autopsy

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

26. Place of Dea			
Or: 45 Nursing H	ome 5	Residence	6 ☐Other (Specify)
at c?	28d. De	scribe how inj	ury occurred

28c. Injury Work 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

3 DOA

Oth

Hospital: 1 ☐ Inpatient

28a. Date of Injury (Month, Day Year)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hef Ahmad

Prince Frederick 100 Ho 32. Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year) 2007 O NUL 5

5 Pending investigation

6 Could not be

certifier

determined

2 ER/Outpatient

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10a-c, ef per inf 870 8-2-07 vt. State of Maryland Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 20**07**" **Physician** 12, 0210 Edward Joseph Conway, Jr. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Emmitsburg Frederick St. Catherine Nursing Home Months Days Hours Min. Hours Am. Date of Birth 9. Birthplace (State or Foreign Mary Land 5. Social Security Number 216-24-0785 7. Age (In yrs. last birthday) 79 Yrs. **Funeral** Year 1928 1 □XM 2 □ F Director Usual Residence of Decedent the Maryland 10a. State FL. 10b. County 10c. City, Town or Location 10d. Inside City Limits **Highlands** item 27 le marked other than "neturel", or Items 23s or 28e-f show other treumstic event, the Modical Examinar must be notified at Sebring 1 ☐ Yes 2X No Director 33870-0000 10g. Citizen of What Country? 10f. Zip Code 207 NE Lakeview Drive 10e. Street and Number death with 7241 Ridge U.S.A. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. . Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 le marked other than "neturel", or Item any Injury or other treumatic event, the Mudical Exemplement ODEs. Tyres 2 N1950 to 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 X Divorced Year or Dates: 1953 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) State Government Surveyor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gertrude O'Hara Edward Joseph Conway, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7241 Ridge Road, Frederick, Maryland 21702 Undine Bennett/Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition Smithsburg Chematory June 13, 2007 Smithsburg, MD 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur A Funeral Service Licensee ^{22. Name and Address of Facility} ford Funeral Home wa 106 Fast Church Street, Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician ZHOMERS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit Due to (or as a consequence of): by Physician/Medicai use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ŏ in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9□ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed? Yes 2 No certificate ha: 25. Was case referred to medical examiner? 1 ☐ Yes To the Hospitel or Attending Physicien: 26. Place of Death (Check only one) Be Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To this 27. Mann Death 28c. Injury at Work? completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 \ Homicide within 24 hours a To the Funerel (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year) 29b. Signature and title of certified 200

20

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician June 10. Frederica Grace Collins 8:20 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nov. | Nov. | 15, 1928 Golden Living Nursing Center Frederick 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 215-26-1120 1 □ M 27 F 78 Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. and the than "natural", or Items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ant: If Item 27 is marked other than "at or ontified at any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 □Yes 2 □XNo Maryland Frederick Director Myersville 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 9127 Myersville Road 21773 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or item edical Examiner r Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: White 2 XXWidowed 4 □ Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Operator US Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wilbur Franklin May Lulu Bidle 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1719 Uhler Lane, Finksburg, MD 21048 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important; if item 27 is any injury or other trau once. Mr. Daryl E. Collins/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Zion Lutheran Cemetery June 14, 2007 Middletown, MD 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donatjøn 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee Keeney and Basford PA Funeral Home Murara 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) andromyora Physician /Medical or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 3 ☐ Ectopic pregnancy Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) ed by the a 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 1 🔲 Inpatient this 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director: /

Baltimore, Maryland 21215-0036

29a. Certifier (Check only one) 29b. Signature and title of certifier

Medical

State

DHMH 17 Rev 1/2001

M

29c. License number D0060417

rohnson

tti Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Dav. Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

Hemen

31. Date filed (Month, Day, Year)

shah mb 65 C Thomas 2. Registrar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 9, 9:20P M Doris Senior Carbaugh June 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Hagerstown 11120 Eastwood Drive If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 💢 England Director 213-40-3359 82 Nov 23. 1924 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland pagesment of Heelih and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ ... any injury or other freumatic event. 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County 1 ☐ Yes 2 No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21742 U.S.A. 11120 Eastwood Dr. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: Š 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 10 File Clerk Publishing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Taylor Anna Senior Jonathan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11120 Eastwood Drive Hagerstown Maryland 21742 Jack Carbaugh / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 □Donation 5 □ Other (Specify) 6/13/2007 Hagerstown, Maryland Rest Haven Cemetery 21. Signature of Funeral Service Licens 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami resulting in death) Last Due to (or as a consequence of): ettending physicien a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Year Month Day 4☐ Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown sete has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan 1 ☐ Yes 2 ☐ No certificete 2 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: 1 | Inpatient 2 Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA this After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Mannes of Death 28b. Time of Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by within 24 hours efter To the Funerel Direct 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 62 30 plane and address of person who completed cause of death (Item 23a) (Type, Print) 3 11110 moli 45511 mis 31. Date filed (M 32. Registrar's Signature State Hegertown in Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 12:25ª M JUNE REGINALD M. COLLINS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **MONTGOMERT** SILVER SPRING HOLY CROSS HOSPITAL 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
DIST. OF COLUMBIA 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** Months Hours Min. 1 → M 2 □ F SEPT. 25. 53 Director 225-78-8550 Usual Residence of Decedent 10d. Inside City Limits should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified</u> at 1√Yes 2 No Director MARYLAND PRINCE GEORGES **GLENARDEN** 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 20706 USA 7904 GRANT DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify. à Year or Dates: 3 Widowed 4 Divorced **BLACK** Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) METRO BUS COMPANY TRAINING INSTRUCTOR and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JESSIE ANN LYLES WILLIAM COLLINS, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health an
important: If item 27 is any Injury or other trausonce. BEATRICE R. COLLINS / WIFE 7904 GRANT DRIVE, GLENARDEN, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 Removal from State ANNANDALE, VIRGINIA PLEASANT VALLEY MEM. PARK JUNE 8, 2007 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility PEYTON FUNERAL HOME 309 N. PATRICK ST., ALEX, VA 22314 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) METASTATIC AVAIL CANCER /Medical Due to (or as a consequence of): Examiner SEIZURE Sequentially list conditions, if any, leading to immediate cause. Enter or deriving Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed HYPERTENSION burial-tran Due to (or as a consequence of): Box 68760. physician DIABETES Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☼ No 24a. Was an autopsy performed? /es 2 - No page 2 certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA ٩ this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After ti After t Certification: (Month, Day Year) Injury 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide 1 🗖 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

State

KANWALJIT NAGI
31. Date filed (Month, Day, Year)
JUN 0 5 2007

51 1500 FOREST GLEN RD., SILVER SPRING, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20056063

JUNE 1, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7818A Diane A. Colliere ,2007 410 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Lanham Doctor's Community Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Days 1 □ M 2 1 F 52 1954 June 20, Delaware 175-46-9620 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notifled at 1Ž∐Yes 2 ☐ No New Carrollton MD Prince George's Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20784 USA 6010 84th Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2K Married 1 ☐ Yes 21☑ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important: If Item 27 Is marked other th any injury or other transmets. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Violet Leyton Maurice Faulkner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6010 84th Avenue, New Carrollton, MD Philip L. Colliere/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 15 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Brentwood, Maryland June 6, 2007 Fort Lincoln Cemetery 22. Name and Address of Facility 4739 Baltimore Avenue, Gasch's Funeral Home, P.A. Hyattsville, MD₂₀₇₈₁ 21. Signature of Funeral Service License MO1491 / behille Marke 23. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due (or as a consequence of): **Physician** resulting in death) /Medical Examiner Pralmonory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and 16 stauchiu Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □ Ectopic pregnancy Month for 1 in the past 12 months? 5 Other (specify) ☐Yes 2☐No detached 9 DUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performe 2 No 2 No 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Injury 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours atter death.

• Funeral Director:
✓ bletely filled in by the fi 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Fun completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific MDD 63157

Maryland

Baltimore,

Division or Vital Records, P.O. Box 68760,

State Registrar

DHMH 17 Rev 1/2001

8100 Good Luckled., Suite 302, Lackan, MD. 20706

o completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 08/6 M 2007 Philmore Clark, III /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hy APB ville Prince 7914 Allendale Drive If Under 1 Year If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Social Security Number **Funeral** Months 579-72-3996 50 1**X** M 2 □ F Director 5-1-1957 Washington, DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show unt: If item 27 is marked other than "natural", or items 24a or 28a-f show unty or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County N Yes 2 No MD Prince George's Hvattsville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7914 Allendale 20785 United States Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1∭TYes 2 □ No If Yes, Give 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ▼ No Specify: **Black** Specify: Completed by 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Worker Private Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event; is once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthurdell Raymond Philmore Clark, 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hyattsville, MD 20785 Arthurdell Clark/ Mother Allendale Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 6/8/2007 Brentwood, MD 22. Name and Address of FacilityFort Lincoln Funeral Home 21. Signature of Funeral Service Brentwood, MD 20722 3401 Bladensburg Road complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final **Physician** Arteriosal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for sele conegouence off Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Hriknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Inpatient Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. signed by t this After within 24 hours after death To the Funeral Director: Hospital completely

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who comp

32. Registrar's Signatu 31. Date filed (Month, Day, Year) JUN 0 5 2007

eted cause of death (Item 23a) (Type, Print)

and manner stated.

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

07-04112 Sidney Clanton, Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			Cei	rtificate	of I	Death					eg. No.	4	و میرا د	1 30	
Physic		Decedent's Nam	e (First, Middl	e,Last)							2	2. Date of Dea Month	Day	Year	3.	Time of Death 1945 hrs	٦
dical Exan	nıner	SIDN 4a. Facility Name (i	EY		CLANTO	N J	R.	. City, Tov	m orlo	eation of	Death	May 30, 2		ounty of De	ath	1945 1115	4
		4a. Facility Name (1			umber)			Capitol			Deall		1	nce Geo			١
Funera		5. Social Security N	Number	6. Sex	7. Age (In yrs. I	ast birthda	iy)	If Under	1 Year	If Under	24Hrs.	8. Date of Bir	th(MM/DD	/ YYYY) 9.	Birthp	lace (State or	┨
Directo		117-40-8		1 XM 2 F	55		Yrs.	Months	Days	Hours	Min.	MAY 2	7 19	52 Fo	Coun	ORTH CAROLINA	
any		Usual Residence of 10a. State	10b. County		10c. City	Town or l	ocatio	n							1	Od. Inside City Limits	٦
*	ـ ال	NY	ERI	E		BUFFA	LO								1	X Yes 2 No	1
larylar 18a-f	Director	10e. Street and Nu	mber					10f. Zip C	ode			1	0g. Citizer	n of What (Country	P	1
ith the Maryland 23a or 28a-f show	븁	1 BURK	E DRIV	E				14	4215				U.	S.A.			۱
≥ a	Funeral	11. Marital Status	ed 2 X M	12. Was De	cedent Ever in U orces? ARM 2 No			Decedent s, specify (cify Yes or No Rican, etc.))- 14	I. Race - Al White, et		n Indian, Black,	1
after d	by Fu	3 Widowed	4 Div	orced If Yes, Give Ye			1 `	Yes 2	No s	specify:			Sp	ecify:	BL.	ACK	
hours afte 'natural'',	d be			cify only highest gra				s Usual Od st of working					16b. Kin	d of Busine	ess/Ind	ustry	٦
036 ithin 72 h ne.	olete	Elementary/Seco	ondary (0-12)		1-4 or 5+)							/	DD.	T T A TUTE			
5-00.3 led withi Hygiene.	Completed	17. Father's Name	(First Middle	4yrs		REAL	ES	TATE			Name (First, Middle.		IVATE			\dashv
D 21215-0036 should be filed within 7 and Mental Hygiene.		SIDNEY	,	,						EVEL		PARKER		,			1
2121 ould be fill d Mental I s marked	I o	19a. Informant's Na										ural Route Nu		or Town, S	tate, Z	ip Code)	1
and 2 shou sealth and N		CAROLYN		E/WIFE								NEW Y		1421			4
Baltimore, Mormit. Pages 1 and 2 Department of Health Important: If item 2	<u> </u>	20a. Method of Dis		n 3 Removal	from State	Place of E crematory	or othe	er place)		_		Date	1	cation - Cit		•	-
Limon Page ment tant:	5	4 Donation 5	-		F	OREST					6/7/	2007				W YORK	4
Baltimo permit. Page Department o Important:		21. Signature	ingent Service	Liteasee				me and A				B. JE LANDOV				L HOME 20785	1
Physicia		23a. Part I. Enter th	ne disease, or	complications that	caused the deat	n. Do not e									T.	Approximate Interval	-
'Medica	al .	failure. List or Immediate Cause		N. A. oldinal - In-	iuries											Between Onset and Death	ļ
tamine	r	or condition resulti			a consequence	of):											٦
	<u>.</u>	Sequentially list co		b.	a consequence	of).									-		-
	n in	if any, leading to in cause. Enter Under (Disease or injury)	erlying Cause		a consequence	or).				- 4							
p :	Examiner	events resulting in		Due to (or as	a consequence	of):											
760, icate be executed physician and the buriel is transit	<u>°</u> l =	UNPENDED)	a AMENDED													┨
760, icate be exe	/Mec	IF FEMALE:			, outcome of pre-	gnancy							23d.	Date of del	ivery		1
Sox 68760, leath certificate be extrending physic for use of the burner	sician/	23b. Was decedent past 12 months		I rive	birth nant at time of d	eath a		al death		Ectopic	pregnar	псу	N	fonth	Da	y Year	
Box e death c the atten	ysic	1 Yes 2	No 9 Un	known	nown	eath 5	Oth	er (Specif	y)				1				9
Records, P.O. Box 68 The law requires that the death certificate has been signed by the attending	/ Phy	Part II. Other sign	ificant condi	tions contributing	to death but not	resulting in	the ur	nderlying c	ause giv	en in Par	t I.					e cause of death?	
ires that the signed by	d by											1Ye	s 2 🗸	No 3	Proba	bly 4 Unknown	
ords w requires been as been a	Completed								_			24a. Was	psy	prio	r to co	psy findings available mpletion of cause of	3
Recol The law	om C												ormed? 2 ✔ No	dea 1	th? Yes	2 X No	
	Be C	25. Was case reference examiner?	rred to medica					26		of Death (Check a	nly one)					\Box
of Vital Records, and Physician: The law require this certificate has been signal diseases and the control of t		1 ✔ Yes	2 No	Hospital: 1	Inpatient 2	ER/Outp			^	-		Home 5 28d. Describe		ce 6 🗸 (Other:	Scene	_
ion of tending Pleath.	<u> </u>	27. Manner of Dea	5 Pen	ding May 30	e of Injury th, Day Year)), 2007	28b. Tin 1856 h		· ·		at Work? es 2 ✔ I	l F	Passenger			in c	ollision	
Division tal or Attendi	fica	2 Accident 3 Suicide		stigation 28e. Pla	ace of Injury - At I	nome, farm	ı, stree	t, factory, o	office bui	ilding, etc				d Number o	or Rura	Route Number, City	,
Diving Biographics and Biograp	Sert	4 Homicide			Major Roa	ad / High	nway					or Town, 95/495 at Ri	itchie Ma	rlboro Ro	ad, Ca	apitol Heights, Md.	
Division of Vital To the Hospital or Attending Physician: within 24 hours after death, To the Funeral Director. After this certification of the constitution of the property of the constitution of the property of the prop	edical (29a. Certifier (Check only one) 2	Certifying P	hysician: To the be iminer:On the basis and manner	of examination	dge, death and/or inv	occurr estigati	ed at the ti on, in my o	ime, date pinion, c	e and plac death occ	ce, and urred at	due to the cau t the time, date	ise(s) and e and plac	manner as e, and due	stated to the	l. cause(s)	
F : 5 E 8	Š Š	29b. Signature and	title of certifi						License				1			h, Day, Year)	
-			V	MA 1	1/				O.C.M	l.E.			May	31, 2007	7		
(7)		30. Name and add		who complete i ca puty Chief Med			l Pen	n Street	, Baltir	more, N	/ID 21:	201					
Reg	State	31. Date filed (Mor	nth, Bay 200	7 / 32.1	Registrar's Signa	ture	W		_								_

DHMH 17 Rev 1/2001

		4	For State Registrar	\$	State o	of Maryla		artmen rtificat		ealth and N Death		giene	007	19552
			1. Decedent's Name (First, Middle	, Last)							2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic		Richard J. Com	os							May 31			3:53PM [™]
	Examin		4a. Facility Name (If not institution	, give str	eet and nu	ımber)		4b. City,	Town, or	Location of Death		4c. Cou	nty of Death	h
			Shady Grove Ad	venti	st H	ospita	1		kvil			Mont	gomer	
	Funeral		5. Social Security Number	6. Sex		7. Age (In y	rs. last birthday)	If Under Months		If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da	y, Year)	9. Birth	nplace (State or Foreign untry)
	Director		223-64-8022	1 🗗 N	4 2□F	59	Yrs.				Dec. 2	, 1947		ginia
	DC		Usual Residence of Decedent			100	City, Town or Lo	tion						10d. Inside City Limits
	show	_	10a. State 10b. County											1 ☐ Yes 2 🛣 No
	Ba-f	ct	Maryland Montg	omery	7	G	aithersl							
	or 21	Directo	10e. Street and Number					10f. Zip				10g. Citizen	of What Co	untry?
	23a	a	18613 Sandpipe	r Lar	1e				20879			United		
	r dea	Funeral	11. Marital Status	12	. Was Dec Armed F	cedent Ever in orces?	n U.S. 13.	Was Deced If Yes, spec	dent of Hi cify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No o Rican, etc.)	- 14. F	Race - Amei Black, White	rican Indian, e, etc.
õ	or it		1 ☐ Never Married 2 ☑ Mar		If Yes, G	2 [X]No ive		1 ☐ Yes	2 X No	Specify:		Spe	cify:	***
21213-0036	be filed within 72 hours after death with the Maryland all typique. An experience 23a or 28a-f show other then "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	3 Widowed 4 Divorced		Year or (Dates:	10.0	de este date				16b. Kind o		ite
ก็	nat dra	Completed	15. Deceder (Specify only highe	t's Educa st grade o	tion completed)	(Give	dent's Usua kind of wo DO NOT us	rk done d	durina most of worl	king	16b. Kinu o	i Dusinessvi	industry
Z	ne. hen	ш	Elementary/Secondary (0-12)		College	(1-4or 5+)				,		City	f Poo	kville, MD
N	e filed within at Hygiene. I other then vent, the We		8 17. Father's Name (First, Middle,	(act)			Supe	ervis	or T	18. Mother's Nam	ne (First Middle			KVIIIe, III
yland	be fi	Be		Last										
	should by the Menta marked matic even	၉	James F. Combs		0.1.4		405-14-20		/011	Dessie I		or City or To	um Ctato 2	Zin Codo)
Mar	2 sh and te m		19a. Informant's Name/Relations					3	,			•		
	ss 1 and 2 should b of Health and Ment item 27 is marked r other traumatic e		James T. Combs	()	Son)	20				Oak Court	t Germa			Town, State
6	H iof H H ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Rer	noval from	1 State	b. Place of Dispo cemetery, cre			F			,	
altimore,	men Tent:		4 □ Donation 5 □ Other (S		1	P	arklawn	Memo:	rial	Park 6	/4/07	Rockvi	lle,	Maryland
<u> </u>	permit. Pages Depertment of t Importent: If its eny injury or of		21. Signature of Eugeral Service	Lico see) 11	(1)	12	2. Name ar O Eas	nd Addres t De	ss of Facility De er Park I	evol Fun Orive	ierai n	ionie	
מ	405 a		X obert	14	no	<i>P</i>	J G	aithe	rsbu	rg, MD Z	00//			A
			23a. Fart1. Enter the disease of shock, or heart failure. Lis	complicationly one	ations that cause on	caused the c each line.	death. Do not en	ter the mod	de of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition		Vent	ricula	r Fibri	llati	on					Minutes
	/Medical		resulting in death)	("			sequence of):							
	Examiner		Sequentially list conditions	b.										
	D =	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	"	Due to	(or as a con	sequence of):							
	nd	am	Cause (Disease or injury that initiated events	c.										
õ	e exe ien a uriat-		resulting in death) Last		Due to	o (or as a con	sequence of):							
8760,	icate be executed physicien and s the burial-transit	dlcal		d.										
ف	ntifica ng pl	0	IF FEMALE:	-										
Box	death certific e attending p ed for use as	an/i	23b. Was decedent pregnant in the past 12 months?	23		utcome of pre birth 2 □ I	Fetel death 3	∐Ectopic p		,		23d.	Date of del Month	livery Day Year
	0 0	200	1 ☐ Yes 2 ☐ No		4∐Preg 9∐Unk	gnant at time nown	of death 5	Other (s	oecity)					,
о <u>.</u>	The law requires that the deste has been signed by the a bage 2 should be detached f	Physician/M	9 Unknown	-2-	-	100000			-	1.0.4	00- Did			the cause of death?
	gned be de	ğ	Part II. Other significant conditi	ons conti	nbuting to	death but not	t resulting in the i	underlying (cause giv	en in Part I.				the cause of death?
ב	w require been si should b	ted	Hypertension								10	Tes ZLIN	0 3	ODADIY 4 ZOTIKITOWIT
ပ္က	aw re as be 2 sh	ple									24a. Was		prior to	utopsy findings available completion of cause of
Vital Records,	tending Physician: The is leath. It to the forth the this certificate hat the funeral director, page the funeral director, page to the funeral director.	Completed									perfo	ormed?	death?	2 □ No
ā	ilcian: Th certificete rector, pag	0	25. Was case referred to medica	al .						26. Place of Dea	ath (Check only	one		
>	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 🖾 No	Ho	spital: 1 [Inpatient	2 ER/Outpatie	nt 3 🗆 D	OA Oth	ier: 4 ☐ Nursing H	lome 5 🗀 Res	idence 6 🗆	Other (Spe	icify)
Ö	g Physier this leral di		27. Manner of Death	///	28a. Date	e of Injury onth, Day Yea	28b. Time (of	28c. Injur Wor		28d. Describe			
<u>ō</u>	Attending I ir death. ector; After by the funer	at o	1 XNatural 5 ☐ Pendi 2 ☐ Accident invest	ng igation	(7800	ann, Day 102	,,.,	M		Yes 2□No				
Division of	l or Attend efter death Director; /	1	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	not be nined	28e. Plac	ce of Injury -	At home, farm, s	treet, factor	y, office		28f. Location (Street and N wn, State)	umber or Ri	ural Route Number,
۵	al or A s efter al Dire	Certification:	T I I I I I I I I I I I I I I I I I I I		, Jun	J. J	,,,							
	To the Hospital or At within 24 hours efter of To the Funeral Direct completely filled in by	sal (29a. Certifier 1 Certify	ng Physi	cian: To the	he best of my	knowledge, dea	th occurred	at the tir	me, date and place opinion, death occu	and due to the	cause(s) and	manner as	s stated.
	hs H in 24 he Fi pletel	edical	one)		and ma	inner stated.	II AND II AND II							
	To t To t	2	29b. Signature and title of certifi	er -	12	, ,	. 0	29	Licens	se number	1	29d. Date si	gned (Mont	th, Day, Year)
}	10		RIS	4	1/2	- 17	.0.		NS	101	1	June	1, 200	07
			30. Name and address of person	who con	npleted ca	use death	(Item 23a) (Type	, Print)	-	/				
			Day 1d Srour, M	D 9	901 N	<u>ledical</u>	l Center	Driv	e, R	ockville	, MD 208	350		
	Sta		31. Date filed (Month, Day, Year	000	7 32	egistrar's S	Signature	a as	3					
	Regist	rar	.111N (1.2	F ZUU	t B	200000	700 300		7					

			For State Registrar	State	of Marylan			of Health		ental Hy	/giene Reg. No	(J.	7 1	9553
	8.		Decedent's Name (First, Middle	e, Last)						2. Date of D	eath			e of Death
	Physicia		Anthony Capaco	hione					1	Month May	Da	^{3y} Ye. 2007	12:4	о рм
	/Medic		4a. Facility Name (If not institution	n, aive street and r	umber)		4b. City, T	own, or Location	of Death	May.		County of D		V
	Examin	er				7		Doglessi 11	0			Moz	ntgomer	.,
	Francis		Shady Grove A 5. Social Security Number	6. Sex	7. Age (In yrs.		day) If Under 1	Rockvill Year If Under	24 Hrs.	8. Date of B	rth	9.	Birthplace (Sta	
	Funeral Director			1√2 M 2□F		Y	rs. Months	Days Hours	Min.	(Month, E	-		Country)	ton, DC
			579-24-0460 Usual Residence of Decedent		80					NOV.		19201	wasiiiig.	LOIL & IX
	/łanc		10a. State 10b. County		10c. Cit	y, Town	or Location						10d. Inside	e City Limits
	Mar	to	Mountain	/antanna			Rockvil	1.0					1 🗆 Y	es 2 ⊋No
	r 28e	Directo	Maryland N 10e. Street and Number	Montgomer	у		10f. Zip (10g. C	itizen of What	Country?	
	3a o		14008 London	Lane			2	0853				USA		
	deati me 2	Funerai	11. Marital Status	12. Was De	cedent Ever in U	.S.	13. Was Decede	ent of Hispanic Or	igin? (Spe	city Yes or N	10-	14. Race - A	merican Indian	1,
ധ	after and a second	E.	1 ☐ Never Married 2 ☐ Mar	ried 1200 Yes	Forces? s 2 ☐ No			fy Cuban, Mexica		nican, etc.)			/hite, etc. White	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or tteme 23e or 28e-f ahow ant, the Medical Examinar must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, 0 Year or	Dates: W	WII	1 Li Yes 2	X No Specify	•			Specify:	WILLCO	
9	72 hc	Completed	15. Deceder (Specify only highe	nt's Education	۸()	16a. l	Decedent's Usual	Occupation k done during mo.	st of worki	na	16b. i	Kind of Busine	ss/Industry	
2	hin a	pie	Elementary/Secondary (0-12)		(1-4or 5+)	1 '	life. DO NOT use	retired)		.9				
2	M P P P P P P P P P P P P P P P P P P P	ő	10				Chief	Engineer					ial Rea	1 Estat
	at Hy oth	Be (17. Father's Name (First, Middle,	Last)				18. Moth	er's Name	(First, Middi	e, Maide	n Su ma me)		
<u> a</u>	uld b Menti rrkad rrkad	10	Liberato Capa	ıcchione					Jenr	y Con	dore			
altimore, Maryland	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23s or 28s-f ahow any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relations				-	(Street and Numb					re, Zip Code)	
Σ	and 2 alth 27 i		June P. Capaco	:hione/Wi	fe	140	008 Lond	on Lane,	Rock	ville	, MD	20853		
re	of He		20a. Method of Disposition	a CD amount to	1 /	Place of I	Disposition (Name, crematory or other	e of her place)	Jur	ne 5,	20c. l	_ocation - City	or Town, State	9
Ĕ	Page ient c int: If		1 PBurial 2 □ Cremation 4 □ Donation 5 □ Other (5					ial Park		007	Rocl	kville	Maryl	and
Ħ	nit.		21. Signature of Funeral Service	Licensee			E22 Name and	Address of Facil						
ä	Per La Contraction of the Contra		A A	<	Q.			versity						20901
			23a. Part1. Enter the disease, o	r complications tha	t caused the deat	th. Do no							Approxi	
			shock, or heart failure. List Immediate Cause (Final			_							Onset a	ind Death
	Physician /Medical		disease or condition resulting in death)		tic Shoc									
	Examiner						r):							
		-	Sequentially list conditions,	D	creatiti Curas a nonsec		9							
	nsit	nine	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<			,							
_	and and	xar	that initiated events resulting in death) Last	c. Due	o (or as a consec	neuce o	f):			_				
8760,	death certificate be executed the ettending physicien and buffer use as the burial-transit	edical Examiner												
87	phys the	g		d										
9 x	eath certific ettending pl for use as t	/Me	IF FEMALE:	23c If yes	outcome of pregn	ancv						23d. Date of	dolaron	
Вох	atten etten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	e birth 2 ☐ Feta	al death	3 Ectopic pre					Month	Day	Year
o o	the d	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Uni		Jeann .	5 Other (spe	эспу)						
P.O.	that the de ned by the e detached f	Physician/M	Part II. Other significant conditi	one contribution to	death but not res	sulting in	the underlying ca	use given in Part		23e Dic	Ltobacco	use contribu	te to the cause	of death?
ŝ	8 50 8	þ				-								√∑Unknown
010	w require been si shoutd I	ted	Hyperkalemia,	Acute R	enal Fai	Lure	Myoca	rdial in	Iarcu	cion -				
Division of Vital Records,	has b	Completed								24a. Wa	opsy	prior	e autopsy findi to completion	ngs available of cause of
<u>~</u>	The ate h	ő									formed? 2 X N	lo 1 🗆	n? Yes 2□ No	
ïa	Physician: r this certificanal director,	Be (25. Was case referred to medica examiner?	il				26. Plac	e of Death	(Check only	one)			
<u></u>	yeic als ce	으	1 ☐ Yes 2 ☐XNo	Hospital:	ZInpatient 2□] ER/Out	patient 3 DO	A Other: 4 D N	lursing Ho	me 5 Re	sidence	6 ☐ Other (Specity)	
0	1g Pt ter th		27. Manner of Death 1 № Natural 5 Pendi		te of Injury onth, Day Year)	28b. T	me of 2	8c. Injury at Work?		28d. Describ	e how inj	ury occurred		
<u>ō</u>	Attending ir death. ector: After by the fune	atic	2 ☐ Accident invest	igation			М	1 ☐ Yes 2 ☐]No					
<u> </u>	ar de	tific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	nined 288. Pla	ice of Injury - At hilding, etc. (Speci		m, street, factory	, office			(Street a		or Rural Route	Number,
Ö	s afte	Certification:												
	hour hour uner			ng Physicien: To										(2)02
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medicai	(Check only 2 Medical one)	Examiner: On the and m	anner stated.	auvii and	or investigation,	army opinion, de	- UCCUIT	oo at trie (im)				
	To With	Σ	29b. Signature and title of certific	er Klou	0.00		_	License number				-	fonth, Day, Yea	ar)
)	20 X		> Sand	eyeu	14)		1	00649	500		Ju	ne 1,	2007	
	~		30. Name and address of person	who completed c	ause of death (Ite	m 23a) (Type, Print)							
			Brian Carpente		9901 M	1edi	cal Cent	er Drive	, Roo	ckvill	e, M	D 2085	0	
le c	Sta	ite	31. Date filed (Month, Day, Year	2007	Registrar's Sign	ature	1.15-				-			
	Regist		JUN U 4	COO!	Registrar's Sign	F 1	PRICE							

07-04237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Robert Collier State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Deat Month Day June 3, 2007 Medical Examiner 2120 hrs ROBERT COLLIER 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Eastern Correctional Inst Westover Somerset 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) N.C. Months Davs Hours Director 1 **X**M 2 F 217-80-4204 46 01-08-1961 Usual Residence of Decedent 10a State 10d. Inside City Limits 10b. County 10c. City, Town or Location Yes 2XX No or 28a-f show notified at once. DELAWARE KENT FREDERICA death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 174 EAST OAK STREET 19946 USA 23a uneral 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, þ Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1 X Yes hours after If Yes, Give Year Widowed Divorced Yes 2 X No specify: Specify: WHITE 2 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done Completed ore, MD 21215-0036
s. I and 2 should be filed within 72 ho
of Health and Mental Hygiene.
If item 27 is marked other than "na during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical COMPUTER PROGRAMMING COMPUTER 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be ROBERT L. COLLIER II RUTH HOLLINGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUTH H. BURNETTE/MOTHER 2856 SKEETER NECK ROAD, FREDERICA, DE. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State Baltimore, or other crematory or other place) 1 XBurial 2 Cremation 3 Removal from State ment o BARRATTS CHAPEL 06-08-2007 FREDERICAL, DELAWARE Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12 LOTUS STREET TRADER FUNERAL HOME INC. us R1 DOVER, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a. Hanging Immediate Cause (Final disease **xamine** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and and Physician/Medical ending physician use as the burial -UNPENDED AMENDED P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown 9 Unknow Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 V No 3 Probably 4 Unknown Division of Vital Records, Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? No Yes 2 ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other 4 Hospital: Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 1 ✓ Yes 2 No 28a. Date of Injury (Month Day,Year) Jun 3, 2007 Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Subject hanged self 1 Natural 2110 hrs Yes 2 V No Pending the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f, Location (Street and Number or Rural Route Number, City 3 🗸 Could not be Suicide or Town, State)
Eastern Correctional Inst, Westover, MD determined (Specify) State Facility Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the ▼ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Stonature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) June 4, 2007 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD.

State Registra

Year) 1 2007

OCME

completely within 2

MP 2

State Registrar

102 31. Date filed (Month, Day, Year)

JUN 04

29b. Signature and title of certifier

SI 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Harring, MD

07-03986

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Desmond Leon E		undson S	State of M	aryland		rtment of l		and	Menta	I Hygiene		. 20	den say	the second
		Registrar 1. Decedent's Name (First, Mic	Idle Last)		Cert		Jean			2. Date of	Reg. Death	No.	3. Time o	of Death
Physicia Medical Examir	ner	Desmond Leon	Edmund							Month May 2	6, 200	ay Year 7 4c. County of Dea	0146	hrs
ť		4a. Facility Name (if not institu Suburban Hospital	tion, give street	and number)	45	. City, To Bethes		cation of [Death		Montgomery		
Funeral		5. Social Security Number	6. Sex	7. Ag	ge (In yrs. la	ast birthday)	If Under		If Under 2		of Birth (MM/DD/YYYY) 9. B	irthplace (St	tate or
Director		216 84 2661	1 * M 2	F	32	Yrs.	Months	Days	Hours	Min. 03/	07/1	_	country)Ma	ryland
,		Usual Residence of Decedent 10a State 10b Count			10c City	Town or Locatio	n						10d. Insi	de City Limits
low any			nce Geo	rges		pital H		s					1 * Y	es 2 No
arylanc Sa-f sh	Director	10e. Street and Number					10f. Zip C	ode			10g	. Citizen of What Co	ountry?	
the M. a or 2:		914 Highview	Drive				207	43			Ur	ited Stat		
h with ems 23	Funeral	11. Marital Status 1 *Never Married 2		Vas Deceden		S. 13. Was	Deceden s, specify	of Hispa Cuban, I	anic Origin Mexican, F	? (Specify Yes Puerto Rican, etc	or No-	14. Race - Ame White, etc.	erican Indiar	n, Black,
er deat			Divorced or Dat		** No	1	Yes 2	No	specify:			Specify: B	Lack	
ours aft	d by	15. Decedent's Education (S	pecify only high	es: nest grade co	mpleted)		s Usual O	ccupatio	n (Give kir	nd of work done	Section	6b. Kind of Busines	s/Industry	
6 n 72 hc an "na ical Ex	Completed	Elementary/Secondary (0-1	2) C	ollege (1-4 or	5+)				r/Lab			Serta Ma	atress	Co.
5-0036 Led within 7 Hygiene. Lother than	E O	9th 17. Father's Name (First, Midd	ile. Last)			Dalli	2 MIG			Name (First, Mi	ddle, Ma			
215. be filed mal Hy rked or	BeC	Derek Wilson	,							ra Edmu				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If itien 27 is marked other than "natural", or items 23n or 23n-f show injury or other traumatic event, the Medical Examiner must be notified at once.	2	19a. Informant's Name/Relation Barbara Edmu:				19b. Mailing Q1Д Н	Address	(Street	and Numb	er or Rural Rout Capital	te Numb Hei	er, City or Town, Sta Lghts, MD	ate, Zip Cod 2074	e) 43
and 2 s ealth a tem 27		20a. Method of Disposition				Place of Disposi	tion (Nam			Date		20c. Location - City		
nt of H		1 🖈 Burial 2 Crema		moval from S		crematory or oth Cesurrec		Cem		06/09/2	007	Clinton,	Mary1	and
Baltimore, permit. Pages I a Department of He Important: If ite		Donation 5 Other 21. Signatur Fun al Serv	Specify:		11							ines Fune		ome, LLC
E: F & F & W		Juan	人分	net		301	5 12	th S	t., N	E Wash	ingt	t, shock, or heart	20017 Approx	ximate Interval
Physician Medical		failure. List only one cau	se on each line	€.			e mode o	uying, s	0011 00 001	Talac of Foophias	o., a	,		en Onset and Death
kaminer		Immediate Cause (Final disea or condition resulting in death		hot wound o (or as a con										
	<u>.</u>	Sequentially list conditions,	b	o (or as a con	sequence o	off):							-	
	Examiner	if any, leading to immediate cause E to Underlying Car (Disease or injury that initiate	d C											
ted 3 msit		events resulting in death) La		o (or as a con	isequence o	of):								
be executed ician and urial - transit	dical	UNPENDED		ENDED										
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funcar after of the funcaral Director. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	ian/Med	IF FEMALE: 23b. Was decedent pregnant		c. If yes, outc	ome of preg		tal dooth	3	Ectonic	pregnancy		23d. Date of deliv	very Day	Year
x 68 h certif tending use as	sician	past 12 months?	4	Live birth Pregnant	at time of de		tal death ner (Spec	ify)	Letopic	pregnancy			,	
Box ne death c the atten	Physi	Part II. Other significant co	Unknown g	Unknown	ath hut not a	reculting in the u	nderlying	cause di	ven in Par	+1 23e	Did to	pacco use contribute	to the caus	e of death?
ords, P.O. Bo w requires that the de s been signed by the should be detached f	宜	Part II. Other significant col	iditions conti	ribuling to de	ath but not i	resulting in the d	indenying	oduse gi	ven in r ui		Yes			
ds, require seen sig	Completed									248	a. Was a			dings available
of Vital Records, ng Physician: The law requir ther this certificate has been s neral director, page 2 should t	ᄪ						_				perform Yes 2	ned? death		2 No
tal Rec ician: The certificate	Be C	25. Was case referred to me								Check only one)			
Of Vita ing Physici After this co	일	examiner? 1 ✓ Yes 2 No	Hospit	- Inpu	itient 2 🗸			<u> </u>	Other ₄	Nursing Home		Residence 6 O	ther:	
n of Niding Phi Iding Phi I. After the funeral		27. Manner of Death 1 Natural 5	Pending	8a. Date of I Month, Da FOUND:	y,Year)	28b. Time of I FOUND:	injury	-	es 2	Subjec				
Division and or Attendin rs after death. al Director: A	ficati	2 Accident	augation .	May 26, 20 28e. Place of	07 f Injury - At h	0042 hrs home, farm, stree	et, factory	office b	uilding, etc		cation (S	treet and Number of	Rural Rout	e Number, City
Divisior: Bospital or Attend 4 Hours after death Funeral Director: etely filled in by the 1	Certification:	4 V Homicide	tetermined	(Specify)						7711 B	urnside	Road, Landover,		
D) To the Hospital within 24 hours: To the Funeral completely filled		29a. Certifier 1 Certifyin one) 2 Medical	g Physician: 1 Examiner:On t	o the best of he basis of e	my knowled	dge, death occui and/or investiga	rred at the	time, da opinion,	ite and pla , death occ	ce, and due to t curred at the tim	he cause le, date a	e(s) and manner as and place, and due t	stated. the cause	(s)
To the within To the complete	Medical	29b. Signature and title of ce	and	manner state	ed				e number			29d. Date signed		
	_	1/1	11	V.	0/77	2		0.0.1	M.E.			May 26, 2007		
2 (2)		I. Name and address of pe					444.5	0:	0	Himans MD	24204			
NR W		Theodore M. King,	·		Medical trags Signa	Examiner	111 Pe	enn Str	eet, Ba	Itimore, MD	Z1ZU1			
S Regis	tate stra	31. Date filed (Month, Day Y	57 Ba	oz. Negis	D. 1	per								

State of Maryland / Department of Health and Mental Hygiene. UU / Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** MAY PM DAVID EAST WALTER 2007 29 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02-10-1948 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min XXM 2□F WASHINGTON DC 59 578-60-4099 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director WALDORF MARYLAND CHARLES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 20601 UNITED STATES 12028 PIERCE ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "naturel", or Iteme 11. Marital Status Black, White, etc. e filed within 72 hours after at Hygiene. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cottege (1-4or 5+) INVENTORY CONTROL SUPERVISOR U.S. GOVERNMENT 12 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Importent: if Item 27 is marked oth any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) HARRIETT N. TURNER LORING WALTER EAST 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12028 PIERCE ROAD, WALDORF, MARYLAND 20601 ANITA C. EAST - WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition JUNE 7, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State CEDAR HILL CEM. 4 ☐ Donation 5 ☐ Other (Specify) 2007 SUITLAND, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HUNTT FUNERAL HOME M00053 lack 18.1 3035 OLD WASHINGTON RD., WALDORF, MD 20601 Swhanny Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final · Antenioschenotic CARdiovascular Disease Physician disease or condition resulting in death) y ears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) signed by the attending physicien and d be detached for use as the burial-transit Exam resulting in death) Last Due to (or as a consequence of): Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Respiratory Failure Voutilator-Dependent Stypentension 1 Yes 2 No 3 Probably 4 nknown Stape Rena, (Disease/Periphera / Vascolar Disease 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Right Holar Musel Pneumonia/Diabetes Millitis Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending м 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

OK to take per Timiki

State Registrar

31. Date filed (Month, Day, Year)

JUN 0 4

DEVORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

use of death (Item 23a) (Type, Print)

WW 4203 Q VEROSSOVARY Rd Hyatts IIe MD 2078/
Rgstrar's Signature

D01752

May 29 2001

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2007 Month Physician June 8, 7:31A Fairnot Jr. Raymond /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Fort Washington Fort Washington Hospital 7. Age (In yrs. last birthday)
60 Yrs.

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 4,1947 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Funeral 1**3** M 2□ F 248-80-3069 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County rthan "natural", or iteme 23a or 28a-f ahow the Madical Examinar must be notified at 1 Yes 2 No Director Fort Washington Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20744 United States 406 Aragona Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1. 2 Yes 2 □ No 72 hours after 1 ☐ Never Married 2 X Married Maryland 21215-0036 399 1 ☐ Yes 2X No Specify: Specify: If Yes, Give Year or Dates: Black δ 3 ☐ Widowed 4 ☐ Divorced leted Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other than "n Compl College (1-4or 5+) Elementary/Secondary (0-12) Currency Distributor Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mattie Hillard Raymond Fairnot Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum. 406 Aragona Drive Fort Washington, Md. 20744 Vivian Fairnot/wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6/13/07 Clinton, Md. Resurrection Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, Md.20746 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alua Physician disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or a a consequence of) certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760,4 Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The faw requires that the death Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 No 1□ Yes of Vital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ZER/Outpatient 3□ DOA Medical Certification; To 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Division Injury 1. Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier lei R.1) Kill aks 1110 20056949 O_{X_j} 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KARAKSHIBAIC STE IDZ , LA PLATA HWY 6620 31. Date filed (Month) Registrar's Signature State Registrar

			For State Registrar	State of Ma	ryland	-	rtment tificate			and M		giene Reg. No. 2 () ()	7 19559
	Physici /Medic		1. Decedent's Name (First, Middle, Las Ethel Mae Foster	t)							2. Date of De Month June 5	Day Ye	3. Time of Death 10:40 A M
	Examir		4a. Facility Name (If not institution, give				4b. City, To					4c. County of I	Death
45.			Homewood at Willia 5. Social Security Number 6. Social Security Number		(In yrs. lasi	t birthdav)	Willi If Under 1		port If Under 2	24 Hrs.	8. Date of Bir	Washing	
4	Funeral Director			□ M 2 7 F	90	Yrs.	Months (Days	Hours	Min.	(Month, Da	y, Year) 24 1917 Ma	Birthplace (State or Foreign Country) aryland
	and W		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Lo	cation						10d. Inside City Limits
	Maryli -f eho	tor	Maryland Washingto	nn e	•	iamsī							1 ☐ Yes 2 No
	th the	irec	10e. Street and Number	711	WILL	Lamor	10f. Zip C	ode				10g. Citizen of Wha	at Country?
	ath wi	rai	16505 Virginia Av				2179					U.S.A.	
920	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23s or 28e-f show event, its Mudical Exemples manual Le notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		lf lf	Was Deceder f Yes, specify	y Cubar	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No Rican, etc.)		American Indian, White, etc. White
21215-0036	72 ho	Completed	15. Decedent's Ed (Specify only highest gra		1	(Give	lent's Usual (done di	uring most	of workii	ng	16b. Kind of Busin	ess/Industry
121	within ene. than	jdmo	Elementary/Secondary (0-12)	College (1-4or 5+			oo not use Mach	,		atar		Clothon N	Manufacturing
d 2	Il Hygie other	Be Co	17. Father's Name (First, Middle, Last)			EMTITE	y Macii.					Maiden Sumame)	danuractur ing
/lan		To B	Daniel Harrison I	eck	_				Minn	ie P	earl Be	entz	
Maryland	12 should be and Ment 7 ie marked		19a. Informant's Name/Relationship (7									er, City or Town, Sta	
	is 1 and 2 should of Health and Mer Item 27 te marke other treumatic	3	Donald E. Foster 20a. Method of Disposition	-	20b. Plac		Virgination (Name natory or other				15 Will ate	Liamsport 20c. Location - Cit	
Baltimore,	permit. Pages Department of the Important: If Ite any injury or of once.		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				en Cem		1	/08/	2007	Hagerston	wn Maryland
alti	permit. DepartmImports Imports any inju		21. Signatur Funeral Service Licen	P								Funeral	
<u>.</u>	20229		mal	200									aryland 21742
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line	9.		SCAS		, such as o	cardiac o	r respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a			5 000						1
0	no St	ner	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Jue to (or as a	cor sequen	iou of):		·					
19	ate be executed hysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	consequen	ice of):							
8760,	sicien buria	ical E		d									
9	tificate ig phys as the			u									N
P.O. Box	that the death certific ed by the attending pi detached for use as f	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal de	ath 3	Ectopic preg Other (spec					23d. Date o Month	f delivery Day Year
	S C 0		Part II. Other significent conditions of Breast Cancer	ontributing to death but	t not resultir	ng in the un	nderlying cau	se give	n in Part I.			,	ite to the cause of death?
Sorc	w require been signature should b	eted					·				10		Probably 4 □Unknown
Division of Vital Records,	The ete h	Completed by	Colon Cancer								24a. Was autoj perfo	osy prio dea	re autopsy findings available r to completion of cause of th? Yes 2 \sum No
Vita	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only o		
ot	Attending Physician: r death. ector: After this certific by the funeral director.	n: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatien 28a. Date of Injury (Month, Day		b. Time of	t 3□ DOA 28d	: Injury Work				dence 6 Other ((Specify)
sior	endin eath. or: Aft he fun	atlo	1 Natural 5 Pending 2 Accident investigation		rear)	Injury	М		es 2 🗆 N	No			
Divis	or Att after de Direct	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At home (Specify)	a, farm, stre	eet, factory, o	office		2	28f. Location (City or To		or Rural Route Number,
	To the Hospitel or Attending Phys within 24 hours alter death. To the Funerel Director: After this completely filled in by the funeral di	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exert	ysician: To the best of iner: On the basis of and manner stat	examination	dge, death and/or inv	occurred at restigation, in	the time	e, date and inion, deat	d place, a	and due to the ad at the time,	cause(s) and manne date and place, and	er as stated. I due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				I .		number			29d. Date signed (A	Month, Day, Year)
			Danetra Ku	ther-	sand	SI W	0	DY	745	1		June 6,	2007
	5		30. Name and address of person who decreased which will be seen a support of the second state of the secon	completed cause of de	ath (Item 23	3a) (Type, 1	Print)	Au	enue	., W	lliam	Sport, M	laryland S
3	Sta Registr	te ar	31. Date filed (Month, Day, Year)	Registra	r's Signature	Box	de				-		

		-	For State Registrar	State of Maryl		artment of H <i>rtificate of L</i>			leg. No.	U /	19061
	sicia edica	n	1. Decedent's Name (First, Middle, Las Raymond Ford,	Sr.				2. Date of Dea Month May	th Day 200	Year 7	3. Time of Death 9:40 p M
	mine ral	r	4a. Facility Name (If not institution, give Joseph RIchey Hos 5. Social Security Number 6. Se 578-74-8829	pice	yrs. last birthday, Yrs.	Baltin	NOTE If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 03-16-	(Year)	9. Birthp	place (State or Foreign pitry)
D			Usual Residence of Decedent 10a. State 10b. County D • C •	10c	. City, Town or L Wasl	ocation nington					0d. Inside City Limits 1X Yes 2 No
th with the 23s or 28s	-	al Director	10e. Street and Number 1320 Fairmont	Street, N.W	. #B1	10f. Zip Code 2000)9	1	10g. Citizen of V	Vhat Cour	ntry?
72 hours after death with the Maryland neture!', or iteme 23a or 28a-f show shall be notified at		by rur	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - Americ k, White, Bla	
within within then.		Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12th	ucation le completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	furing most of worki)	ing	16b. Kind of Bu		
Mar y farror & nd 2 should be filed the and Mental Hygis 27 is marked other traumatic event.		lo Be Co	17. Father's Name (First, Middle, Last) Francis A. For	cd .	Resid	ienciai Ma	18. Mother's Name	(First, Middle, I	Maiden Suman		
	i		19a. Informant's Name/Relationship (7) Daniel Bethea/Guar	dian	7710 Capi	ng Address (Street a) Orange T tol Heigh	ree Court	land, 20	743		
Pege nt: ff			20a. Method of Disposition 1 ☐ Burial 2	Removal from State	Chesapea	matory or other place Lke Cremat Name and Addres	ory 06-07	7 - 07 B		le,	Maryland
permit. Departminents	once		23a. Part1. Enter the disease, or comp	Egeon, CC	36/ 3	4471 4th	Street, N	N.W. WDC	20010	IT HO	Me, Inc.
hysicien and physicien and physicien and sihe buriar-transit	al er	edical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a conduction of the conduction	sequence of):	EVOLU	DMJ.	W/Th	ner	18	Interval Between Onserland Death
death certii e attending od for use a		Ξ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ £ 4 □ Pregnant at time 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Dat Mor	e of delive	ory Day Year
law requires that the as been signed by the 2 should be detached	i i	2	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying cause give	on in Part I.			/	ne cause of death?
The ate h		compiered						24a. Was a autops perform	med?	Vere autoprior to condeath?	psy findings available npletion of cause of 2 No
ding Phys After this funeral dii		2	25. Was case referred to medical examiner? 1	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea 28e. Place of Injury - Industrial Suits of Injury - Inj	At home, farm, str	f 28c. Injury Work M 1 1	at 2 (es 2 No		ence 6 Uthors injury occurr	ed	· reprox
Hospite 4 hours Funerel	. 601	Medical	29a. Certifier (Check only one) 1 Certifying Phy	sician: To the best of my iner: On the basis of exan and manner stated.	knowledge, deat nination and/or in	h occurred at the tim vestigation, in my op	e, date and place, a inion, death occurre	and due to the ca	ause(s) and ma ate and place, a	nner as st and due to	ated. the cause(s)
To the within 2 To the complet)		29b. Signature and attle of certifier 30. Name and address of others who co	MAL Morphys of death ((D)	29c. License	number 90/2	2	9d. Date six ed	(Mosth,	Day, Year)
	State	9	31. Date filed (Month, Day, Year)	32. Registrar's S	naer	WROA!	14 8	110, 1	My .	2/	2/8

, ,		9	1	1
Reg I	No	6	U	

			- negistrar									•		rieg. 140,		1 5 0 0	
	Physici	an	1. Decedent's Name	(First, Middle, La	st)								2. Date of I Month	Death Day	Year	3. Time of Death	
	/Medi		Philip Melvin Feldman										May	31	2007		
	Examir	ner	4a. Facility Name (If n	not institution, giv	e street and п	umber)			4b. City, Town, or Location of Death					4c. County of Death			
			Shady Grove							Rockv					Montgon	-	
Ø.	Funeral		5. Social Security Nur			7. Age	(Iп yrs. las		If Under Months	1 Year Days	If Unde Hours	r 24 Hrs. Min.	8. Date of E	Birth Da <i>y, Y</i> ea <i>r)</i>	9. Birt	hplace (State or Foreign ountry)	
ш	Director	١.	493-44-297	78	⊠ M 2□F		65	Yrs.						24, 19		issouri	
	pr ,		Usual Residence of D				10 07 7										
	how		10a. State	10b. County			10c. City, 1	lown or Lo	cation							10d. Inside City Limits	
	e Ma la-f s	cto	Maryland	Montgon	ery				Potoma	ıc						1 ¥Yes 2 No	
	or 28	Director	10e. Street and Numb	oer					10f. Zip	Code			10g. Citizen of What Country			ountry?	
	h wil	a C	10621 Ta	anager Lan	e			20854							U.S.A	١.	
	deat	Funeral	11. Marital Status		12. Was Dec		ver in U.S.	13. \	Was Dece	dent of H	ispanic C	rigin? (Sp	ecify Yes or I	No- 1	4. Race - Ame		
9	after or ite		1 Never Marrie	d 2X Married		2 K N	0		Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc 1 ☐ Yes 2 ☒ No Specify:				nican, etc.)		Black, White	e, etc.	
8	al", c	by	3 ☐ Widowed 4	Divorced	If Yes, G Year or I				TEL Tes ZEE NO Specify.					Specify: Ca	ucasian		
9	be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed		5. Decedent's E		,	II.		edent's Usual Occupation e kind of work done during most of workin				ina	16b. Kin	d of Business/	Industry	
2	hin 7	pld	Elementary/Second		grade completed) College (1-4or 5+)		F)	life. I	life. DO NOT use retired)			arry					
7	gien the	ĕ		, , ,					Busin	ess 0)wner				Copying		
פ	be filed ntal Hygia ed other event, tl	Be	17. Father's Name (F	irst, Middle, Last)						18. Mot	her's Nam	e (First, Midd	le, Maiden S	Gurname)		
Maryland 21215-0036	lid be lenta rked ic ev	To E	Mike Fe	ldman								Rose	Weiner				
3	s 1 and 2 should be filed v f Health and Mental Hygic item 27 is marked other i other traumatic event, <u>tt</u>		19a. Informant's Nan	ne/Relationship (Type. Print)			19b. Mailir	ng Address	(Street	and Num	ber or Rur	ral Route Nun	nber, City or	Town, State, 2	Zip Code)	
ž	d 2 th a th a tra		Helene Fe	ldman - Wi				10621	Tanao	er La	ne. T	Potoma	ac, Maryland 20854				
Baltimore,	Health Health tem 27		20a. Method of Dispo				20b. Plac	e of Dispo	sition (Nar	ne of	1		Date		ation - City or	Town, State	
<u>ō</u>	ages nt of t; f it		1 🗷 Burial 2 🗆	_	_	n State		netery, cirer	-	•	i		2 0007	01			
뜵	t. Partme		4 □ Donation 5 □ Other (<i>Specify</i>)												Land		
<u>ജ</u>	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other	l	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Mary														
_	⊕ ⊓ = 16 O			Nen							_				ing, Mar		
п			23a. Part . Enter the shock, or heart	e disease, or com failure. List only	plications that one cause on	caused each lin	the death. e.	Do not ent	er the mod	le of dyin	ig, such a	is cardiac	or respiratory	arrest,		Approximate Interval Between	
	Physician		Immediate Cause (Fi	inal	Pn	eumor	nia									Onset and Death 18 days	
	/Medical		resulting in death)		Due to	o (or as a	consequer	nce of):									
N	Examiner		0	Part	b. Septic Shock												
10	1770	Jer	Sequentially list condificant, leading to immorause. Enter Underly Cause (Disease or in	nediate			consequer	nce of):									
	uted d ansit	Ē	Cause (Disease or in that initiated events	jury	c. Multiorgan System Failure												
Ć.	exec in an ial-tr	Examine	resulting in death) Last Due to (or as a consequence of):														
)9/	e be sicia bur																
.89	ficat p phy is the	èdi															
Box 68760,	ith certificate be executed tending physician and ir use as the burial-transit	an/Medical	IF FEMALE: 23b. Was decedent p	rognant	23c. If yes, or	utcome p	of pregnanc	:y						25	3d. Date of del	livery	
ĕ	atter for u	ciar	in the past 12 m	nonths?	1□Live 4□Pred	birth 2	2 ☐ Fetal detime of deat	eath 3□ th 5□	∃Ectopic pr ∃Other <i>(sp</i>	regnancy	/				Month	Day Year	
o.	he de the a	Physicia	1 ☐ Yes 2 ☐ 9 ☐ Unknown	No	9□Unk			0	_ 0.1.0, (op					`			
<u>α</u>	requires that the death een signed by the atter nould be detached for u	윤	Part II. Other signific	ant conditions	contributing to	death bu	t not resultii	na in the u	nderlyina c	ause give	ел in Par	t I.	23e. Die	d tobacco us	e contribute to	the cause of death?	
ည်	signe signe	by			3				, ,	3			1 [Yes 2	ìNo 3∏ Pi	robably 4 🗷 Unknowr	
0	w require been sign	Completed													, 0		
မင	The law te has b page 2 sh	ple											24a. Wa	topsy	prior to	utopsy findings available completion of cause of	
<u> </u>		,ou											pe	rformed?	death?	2 □ No	
<u> </u>	iclan: Th certificate ector, pag	Be C	25. Was case referre	d to medical	·					0.00	26. Pla	ce of Deat	h (Check onl	v one)			
>	Physiclan: this certific ral director,	0	examiner? 1 ☐ Yes 2 🔼 N	o	Hospital:	Inpatier	nt 2 EF	R/Outpatier	nt 3□ DC	OA Oth	er: 4 🗆 I	Nursing Ho	ome 5□Re	sidence 6	□Other (Spe	ecify)	
0	rding Physician: th. : A er this certifica ? tureral director, p	Ë	27. Manner of Death		28a. Date			8b. Time o	f 2	8c. Injur			28d. Describ			,,	
ō	Attending r death. ector: A er by the fune	ē	1 XNatural 2 ☐ Accident	5 ☐ Pending investigation	,	nth, Day	rear)	Injury	м		k? Yes 2[□No					
<u>is</u>	or Attence frer death Director: in by the	fica	3 ☐ Suicide	6 Could not b	28e. Plac	e of inju	ry - At home	e, farm, str	eet, factory	, office			28f. Location	(Street and	Number or Ri	ural Route Number,	
Division or Vital Records,	fter Dire	Certification:	4 ☐ Hamicide determined building, etc. (Specify)										City or 1	ōwn, State)			
	To the Hospital or Attent within 24 hours after death Fo the Funeral Director: completely filled in by the		29a. Certifier 1	☑ Certifying Pl	nysician: To th	ne best o	f my knowle	edge, deat	h occurred	at the tir	ne, date	and place.	and due to the	ne cause(s)	and manner as	s stated.	
	Hos 24 h Fur stely	edical		Medical Exa	miner: On the		examination										
	To the within 2 To the complet	Med	29b. Signature and ti	tle of certifier	anu illa	mier sta			290	. License	e numbe			29d Date	signed (Mont	th. Dav. Year)	
			▶ 12 P		1011							502		000			
•	12		Da	Myen	Je W	1)				JU	UT	100		mai	1 211	2007	
			30. Name and address	ss of prson who	completed cau	use of de	ath (Item 2:	3a) (Type,	Print)								

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 4 2007

Brian Carpenter, M.D., 9901 Medical Center Drive, Rockville, Maryland 20850

32. Registrar's Signature

			State State Registrar		artment of Health and M rtificate of Death	fental Hygie Reg.	- 700 / 195h /
15	- 11		negistrar Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
16	Physicia		Elsie Rebecca Get	7		June 11	Day 2007 3:30 p. ^M
	/Medic Examin		4a. Facility Name (If not institution, give street ar		4b. City, Town, or Location of Death	June 11	4c. County of Death
	- Adiiiii	Ċ1	Beverly Living Cent	er	Cumberland		Allegany
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9 Birthplace (State or Foreign
ш	Director		235-66-9153	64 Yrs.	Willis Days Hours Will.	Dec. 8,19	Barton, MD
	pu ,		Usual Residence of Decedent	10c. City, Town or Lo	postion		10d. Inside City Limits
	aryla shov dat	_	10a. State 10b. County	Toc. City, Town of Ec	Callott		1 X Yes 2 □ No
	he M 28a-f otifie	Director	WV Mineral	Keys	10f. Zip Code	100	Citizen of What Country?
	with t	声	10e. Street and Number			109.	
	eath Is 23 must	Funeral	163 Parkview Drive 11. Marital Status 12. Was	Decedent Ever in U.S. 13.	26726 Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - American Indian,
	ter d item	F	Arm	ed Forces? Yes 2 🙀 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
336	al", or	by		es, Give ** r or Dates:	1 ☐ Yes 2 ∏ No Specify:		Specify: White
21215-0036	within 72 hours after death with the Maryland ene. than "hatural", or items 23a or 28a-f show the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade compl	16a. Dece	dent's Usual Occupation	161	b. Kind of Business/Industry
218	e. an "r	ed .		ege (1-4or 5+)	kind of work done during most of work DO NOT use retired)	ang	
	er th	5	12	Но	omemaker		Own Home
pu	tal H d oth	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Mai	
yla	2 should be filed withir n and Mental Hygiene. is marked other than raumatic event, the Ms	မ	Burley L. Rohrbaugh			Rebecca H	
Maryland	12 sh h and 7 is n traun		19a. Informant's Name/Relationship (Type. Prin	,	ng Address (Street and Number or Ru	•	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Merital Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Rev. Charles W. Getz 20a. Method of Disposition	20b. Place of Dispo	Box 451 Hancock		C. Location - City or Town, State
Baltimore,	Pages nent of I int: If ite iry or o		1 X Burial 2 ☐ Cremation 3 ☐ Removal	from State	matory or other place) June		
퍒	permit. Page Department of Important: If any Injury or once,		4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service Licenses		111e Cemetery 200 2. Name and Address of Facility $S_{ m m}$	7 \perp Larith Funer	ahmansville, WV
Ba	permi Depar Impor any Ir		Houan A	THE	85 S. Main Street		
			23a. Part1. Enter the disease, or complications	that caused the death. Do not en			
	Physician		shock, or heart failure. List only one caus Immediate Cause (Final	e on each line	vele		Onset and Death
	/Medical		disease or condition resulting in death)	ue to (or as a consequence of):			
50	Examiner		b =				
	T #	ner	Sequentially list conditions, if any, leading to immediate Cause (Disease or Injury that initiated events c	ue to (or as a consequence of):			<u> </u>
BS	xecuter and ii-transi	ami	Cause (Disease or injury that initiated events resulting in death) Last				
90,	ate be executed hysician and the burial-transit	ũ	resulting in deathy Last	ue to (or as a consequence of):			
8760,		dical Examiner	d				
9 ×	ding p	/Me	IF FEMALE: 23c. If yo	es, outcome pf pregnancy			23d. Date of delivery
Вох	atten for us	cian	in the past 12 months?	lLive birth 2 ☐ Fetal death 3 l	□Ectopic pregnancy □ Other (specify)		Month Day Year
P.O.	the d	Physician/Me		Unknown	(4-1-7)		
	w requires that the death certific been signed by the attending p should be detached for use as	y Ph	Part II. Other significant conditions contributing	g to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
rds	quires n sign	Completed by	Bipolan a	liseese		1 ☐ Yes	2 No 3 Probably 4 Unknown
00	s bee	lete	•			24a. Was an	24b. Were autopsy findings available
Re	The law ite has b	omp				autopsy performe 1∐ Yes 2 2	prior to completion of cause of death? No 1 □ Yes 2 □ No
ta	(0 24	Be C	25. Was case referred to medical		26. Place of Dea	th (Check only one)	ESSINO PETROS EL TRO
>	Physician: this certificral director, i	To B	examiner? 1 Yes 2 No Hospital	1 ☐ Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Other: 4 Nursing H	ome 5 Residence	ce 6 □Other (Specify)
0	ng Ph fter th neral		27. Manner of leath 28a 1 Natural 5 Pending	Date of Injury 28b. Time (Month, Day Year) Injury		28d. Describe how	
<u>S</u>	Attending r death. ector: After oy the funer	atic	2 Accident investigation		M 1 ☐ Yes 2 ☐ No		
Division or Vital Records,	or Att ter de lirect	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e	Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town,	et and Number or Rural Route Number, State)
Ω	urs af eral D	Se	On a life Manufator Physician	To the best of mulmoudedge, dee	ath accounted at the time, data and place	and due to the cou	uso(s) and manner as atotad
	Hosp 24 ho Fune stely f	Medical	(Check only 2 Medical Examiner: O	n the basis of my knowledge, dean the basis of examination and/or i d manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	urred at the time, dat	e and place, and due to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Mec	29b. Signature and title of certifier	aamor otalida.	29c. License number	290	d. Date signed (Month, Day, Year)
	⊢ ≯ ⊢ Ö		MA L NE DA	ISPANI (MA	N 200641	6	6-12-07
	. 1		30. Name and address of person who complete	ed cause of death (Item 23a) (Type			
	1/		Noshin Oaisrani. M.	D. 447 Virginia	a Avenue Cumberla	and, MD	21502
*	St	ate	31. Date filed (Month, Day, Year)	3 Registrar's Signature	acts in		
	Regist	rar	JUN 1 8 2007	CORNE IS A			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1:35 P^M 2007 May 19, Lawrence Glassman /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bethesda Juder 1 Year | If Under 24 Hrs. Days | Hours | Min. HCR Manor Care 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 XM 2 ☐ F Director 013-01-0887 98 Jun 13, 1908 Massachusetts Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at 10b. County 1 ☐ Yes 2 XNo **Funeral Director** Maryland_ Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code h and Mental Hygiene. 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r 2203 Quinton Rd 20910 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Patent Attorney U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ္ Philip Glassman <u>Annie Skelskie</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Judith Duffie/Daughter 13224 Chestnut Oak Dr. Darnestown, MD 20878 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5 **= 6** 1 I Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any Injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance May 21, 2007 Clarksburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home udeu 11800 New Hampshire Ave. Silver Spring, MD 20910 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, of complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CORONALY ARTERY /Medical Due to (or as a consequence of): **Examiner** CONGESTIVE Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1□ Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 Natural Injury within 24 hours and To the Funeral Director; Af 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1300, mo 00057124 5130107

State Registrar

MD

JUN 0 4 2007

Troung Bao,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9715 Medical Center Dr. #201, Rockville, MD 20850

			State of Maryland / Department of Healt 1 - State Cartificate of Dea	
			Registrar Oct initiate of Dea	Reg. No. 2. Date of Death 3. Time of Death
Ţ.	Physicia	an	1. Decedent's Name (First, Middle, Last)	Month Day Year
*	/Medic		George C. Goggin 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locati	ndy 51, 200, 1.04
7	Examin	er	Montgomery General Hospital Olney	Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Un	nder 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
	Director		218-24-6786 VEM 2 F 76 Yrs. Months Days Hou	urs Min. (Month, Day, Year) Country) July 16, 1930 New York
	ը .		Usual Residence of Decedent	40.11.11.01.11.11
	arylar show d at	_	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 ☐ Yes 2
	ne Ma 8a-f	Director	Maryland Montgomery Silver Spring	
	or 2		10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
	J within 72 hours after death with the Maryland giene. r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	Funeral	13103 Collingwood Terrace 2090	
	Item Item	Š	Armed Forces? If Yes, specify Cuban, Mer	Black, White, etc.
21215-0036	irs af	by	1 □ Never Married 2 ★ Married 1 ★ TXYes 2 □ No 1 □ Yes 2 □ No 1 □ Yes 2 □ No 5 pe 1 □ Yes 2 □ No 5 pe	specify: Specify:White
ö	2 hou atura cal E	De le	15 Decedent's Education 16a Decedent's Usual Occupation	16b. Kind of Business/Industry
215	within 72 iene. than "nai ne M dic	Completed	(Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	most or working
21	d within giene. er than , the M	등	4 Communications	s Director Trade Association
pu	be filed tal Hygie d other event, the	Be (Mother's Name (First, Middle, Maiden Surname)
yla	ould be Menta larked	၉		ldred Clay
Maryland	2 sho			lumber or Rural Route Number, City or Town, State, Zip Code) od Terrace, Silver Spring, MD 20904
	is 1 and 2 should be filed by Health and Mental Hyg Item 27 is marked othe other traumatic event,		20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20c. Location - City or Town, State
Baltimore,	# O .		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)	June 4,
語	it. Partment		4 □ Donation 5 □ Other (Specify) Gate of Heaven Cemeter 21. Signature of Funeral Service Liepnsee 22. Name and Address of E	, i billing, iida yadiid
Ba	permit. Page Department of Important: If any Injury or once,			fallyins Funeral Home Inc. ty Blvd, W, Silver Spring, MD 20901
L	3		23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock or heart failure. List only one cause on such line.	ch as cardiac or respiratory arrest, Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Acute Cavadiac An	Onset and Death
	/Medical		resulting in death) Due ty (or as a consequence of):	0 0 7.
	Examiner		Sequentially list conditions, b. Atheroscher-tic Ca	rdionsular Disease Years
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. Enter Underlying cause.	
	xecut and I-tran	Examine	Cause (Disease or injury that initiated events c	
38760,	cate be executed physician and the burial-transit	a		
587		edical	d	
Box (death certifi e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy	23d. Date of delivery
m	death atte	icial	in the past 12 months? 1	Month Day Year
0		hys	9□Unknown	
Ç,	The law requires that the tte has been signed by those 2 should be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F	Part I. 23e. Did tobacco use contribute to the cause of death?
Records,	w require been sig should b			1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
ည္ထ	e law re has ber je 2 sho	Completed		24a. Was an autopsy findings available prior to completion of cause of
<u>m</u>		mo		performed? death? 1
or Vital	an: tor,	Be (examinat:	Place of Death (Check only one)
7	Physical this cerral direc	2	1 Yes 2 No decli red Hospital: 1 Inpatient 2 JeR/Outpatient 3 DOA Other: 4	□ Nursing Home 5 □ Residence 6 □Other (Specify)
		ë ::	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work?	28d. Describe how injury occurred
Sig	ttend death ttor: /	cati	2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number,
Division	Hospital or Attending 44 hours after death. Funeral Director: After tely filled in by the fune	Certification:	4 Homicide determined building, etc. (Specify)	City or Town, State)
	splta lours neral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, da	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinior and manner stated.	
	To the l	Σ	29b. Signature and title of certifier Med Director 29c. License num	nber 29d. Date signed (Month, Day, Year)
)	1041		Mullus Kein MD MOH DOOS	50410 3/31/0/
			30. Name artifaddress of person who completed cause of death (Item 23a) (Type, Print) MI Charl Rewill 18701 Prina Philip	Dr. Olney MD 20832
1		ate	31. Date filed (Month, Day, Year) 32 Aegistrar's Signature	, - 7
	Regist	rar	JUN 0 4 2007 Brown & Aprile	

DHMH 17 Rev 1/2001

07-04416 Rich

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

20	97	garage a		6	

nard Konaid	Gra	1- F	or State	ale of Marylan	Certifi	cate of	Death				g. No		
Physici	ian/	Req 1. E	istrar Decedent's Name (First, Middle	e,Last)			-		1 1		Day Year	3. Time of Death 0936 hrs	
dical Exam			Richard	Rona	ld	140	Gray b. City, Town, or	Location of I		une 9, 200	4c. County of	f Death	\dashv
			Facility Name (if not institution 16906 Magruders Ferr		ber)	**	Brandywine				Prince G	•	
					. Age (in yrs. iast i	oirthday)	If Under 1 Yea	r If Under		. Date of Birth	(MM/DD/YYYY	9. Birthplace (State or	\Box
Funeral Director		1	15-62-5671	1XM 2F	53	Yrs.	Months Day	s Hours	Min.	03/30	/1954	Foreign Marylan Country	la
any.			ual Residence of Decedent a. State 10b. County		10c. City, To	wn or Location	on					10d. Inside City Li	
and show	5	Ma	aryland Prin	nce Georg	es Bra	andyw	ine			10	g. Citizen of Wi	at Country?	-
Maryl -28a-	Maryland Prince Georges Brandyv Mental Hydicine within 12 bronus after the Maryland Prince Georges Brandyv Mental Hydicine 100e. Street and Number 10e. Street and Number 11. Marital Status 12. Was Decedent Ever in U.S. 13. Worder Great in the Maryland Prince Georges Brandyv 15. Decedent Ever in U.S. 15. Decedent Ever in U.S. 16. Armed Forces? 17. Yes 2 2 X No 18. Armed Forces? 18. Armed Forces? 19. Decedent Ever in U.S. 19. Armed Forces? 19. Decedent Ever in U.S. 19. Armed Forces? 19. Armed Forces? 19. Decedent Ever in U.S. 19. Armed Forces?						206	:12			USA		
ith the	E		Marital Status	12. Was Dece	dent Ever in U.S.	13. Wa	s Decedent of Hi	spanic Origin	n? (Spec	ify Yes or No-	14. Race	- American Indian, Black, e, etc.	
sath w items	Funeral	1	X Never Married 2 M				es, specify Cuba		Puerto Ri	can, etc.)			23
fler de	P F	- l 3		vorced If Yes, Give Yeer			Yes 2 X No		ind of wo	rk done		Black usiness/Industry	
ours a	5		15. Decedent's Education (Spe			6a. Deceden during m	nt's Usual Occupa ost of working life	e. DO NOT u	use retire	d)	Top. rand or b		
72 h	al de		Elementary/Secondary (0-12)) College (1-	40(54)	Fari	mer					culture	
d withi	Completed	5 17	I ∠ 7. Father's Name (First, Middle	e, Last)							Maiden Surnam		
21215-0036 Juld be filed within 7 I Mental Hygiene. I marked other than	Ent, In	왕 E	Daniel			Gra	У	Mar	У	V Irol Poute Nur	mber City or To	Savoy vn, State, Zip Code) 20 (608
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. tem 27 is married other than "natural", or items 23a or 28a-f she) E	2 19	9a. Informant's Name/Relation			19b. Mailin	g Address (Stre	A Para	l lei	n St.	Aguas	co, Maryland	d
e, MD 1 and 2 show Health and item 27 is	traumatic	N	Melvin Gray/	Brother	20b. Pla	ace of Dispos	sition (Name of c			Date	20c. Location	- City or Town, State	
of 1st	ther tr	1	1 X Burial 2 Crematic		om State i	ematory or of	ther place) ection		6/1	8/07	Clint	on, Maryla	nd
Pag Pag nent	5	4	Donation 5 Other St. Signature of Furieral Service	Specify:	I I I	22.	Name and Addre	ss of Facility	Ada	ams Fi	uneral	Home PA	
Balti permit Departr Import	injury		$\mathcal{I}(\mathcal{I}(\mathcal{I}))$	6	191	bn	608 Ag	nasco	b R d	. Agai	uasco.	Maryland20	608
Physicia	an	2	3a. Part I. Exter the disease, of failure. List only one caus	or complications that c	aused the death. I	Do not enter	the mode of dyin	g, such as c	ardiac or	respiratory ar	rest, snock, or r	Between Onse Death	et and
'Medic kamin		١,	Immediate Cause (Final diseas	_{se a.} Hyperta	ensive ath		rotic can	liovascı	ular c	lisease			
Zanini	.		or condition resulting in death)		consequence of)	:							
	1	ਨ li	Sequentially list conditions, if any, leading to immediate		consequence of	:							
	- ·	EΙ	cause. Enter Underlying Caus (Disease or injury that initiated	Due to for on	a consequence of):							
ited d	ansit	֓֞֜֞֞֞֞֞֞֓֞֓֞֓֞֓֓֡֞֞֓֓֡֡	events resulting in death) Las	d									
executed	ial - tr	Medical	X UNPENDED	#23a,2	7, perME, g	868, 6/	19/07 TT						
760, cate be			IF FEMALE: 23b. Was decedent pregnant in	23c. If yes,	outcome of pregr	nancy		3 Ectop	ic pregna	ncy	23d. Date Month	of delivery Day Ye	ear
68 certifi	ise as	cian	past 12 months?		nant at time of de		Other (Specify)						
Box 687 death certificathe attending p	d for t	Physician/		Unknown 9 Unkr				a siven in E	Port I	23e Did	tobacco use co	ntribute to the cause of dea	ath?
O. In all the cd by t		by P	Part II. Other significant con	ditions contributing	to death but not re	sulting in the	e underlying cau	se giveri iii r	ait i.			3 Probably 4 Vul	
uires th	ا ق	70								24a. Wa		b. Were autopsy findings a prior to completion of ca	vailable
ord:	shou	E E								pe	topsy rformed?	death?	No
Zec The la	page	Completed					26 P	lace of Deat	h (Check		s 2 No	Tes 2	
cian:	rector,	Be (25. Was case referred to med examiner?	Hospital:	Inpatient 2	ER/Outpatie		Other ₄		ng Home 5	Residence	6 Other: Scene	
of ∠ i Physi	er uns	유	1 ✓ Yes 2 No 27. Manner of Death	28a. Da	te of Injury hth, Day,Year)	28b. Time	of Injury 28c.	Injury at Wo		28d. Descrit	e how injury oc	curred	
nding	e fun	io	1 X Natural 5 P	Pending				Yes 2				N	han City
The part of the past 12 months? The part of the past 12 months? The pa						treet, factory, off	ice building,	etc.		n (Street and Ni n, State)	mber or Rural Route Number	per, City	
Dital o	eral D	Serti	d d	determined (Specif					mlana an	d due to the C	ause(s) and ma	oner as stated.	
Fo the Hospita	e Filti	g	29a. Certifier (Check only one) Certifying Medical	ng Physician: To the b	est of my knowled is of examination a	ige, death oc and/or invest	ccurred at the tim tigation, in my op	e, date and inion, death	occurred	at the time, d	ate and place, a	nd due to the cause(s)	
To th	comp	Medical	29b. Signature and title of ce	and manne	r stated.			cense numb			29d. Date	signed (Month, Day, Year)	
		2	230. Signature and the orec				ا ا	CME			June 10	2007	
			(Blin)	R.				.C.M.E.				, 2001	
			30. Name and address of pe	rson who completed ca	ause of death (Iter	m 23a)							
NB			30. Name and address of pe Ana Rubio MD.	Assistant Medica	ause of death (Iter al Examiner Resistrar's Signa	111 Pen	n Street, Bal		1D 2120)1			

		For State Registrar	State of Mary	land / Dep		lealth and M	lental Hygi	ene 007	19565			
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Later BRADY JAMES 4a, Fecility Name (If not institution, gives Southern MARY	GESL-S	1	4b. City, Town, o	r Location of Death	2. Date of Death Month	Day Year 9 200 4c. County of Dear PRINCE				
Funeral Director		5. Social Security Number 6. S NONE Usual Residence of Decedent	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min. 20	8. Date of Birth (Month, Day, 6-9-0	Year) 9. Bin	hplace (State or Foreign unitry)					
the Maryland 28e-f show	Director	10a. State 10b. County MD • CHARLI 10e. Street and Number		c. City, Town or	POMFRET 10f. Zip Code		10	10d. Inside Cit 1 Yes 10g. Citizen of What Country?				
er death v Items 23e	by Funeral	8760 MARSHAI 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			675 tispanic Origin? (Spean, Mexican, Puerto		U.S.A. 14. Race - Ame Black, Whit	erican Indian,			
21215-00 1 within 72 hou jiene. r then "nature tre Mexical E	Completed	15. Decedent's E. (Specify only highest gra		(Gi	cedent's Usual Occup ve kind of work done DO NOT use retired INFANT	during most of worki	ing	NONE	/Industry			
E ag la g	To Be Co	17. Father's Name (First, Middle, Last, DAVID CARL SE	IEGGRUD			18. Mother's Name	ELISSA	Maiden Sumame) GESL	- 444.c			
or Heal		19a. Informant's Name/Relationship (DAVID SHEGGRU 20a. Method of Disposition 1 □ Burial 2 ∰ remation 3 □	JD-FATHER	876	A STATE OF THE STA	ALL CORN	ER RD.	City or Town, State, POMFRET, 20c. Location - City or	MD.20675			
Baltimore, permit. Pages 1 ar Department of Hear Importent: If item: any injury or other once.		*4 Donation 5 Other (Special Signature of Juneral Service Lices	y) METRO		N CREMATE 22. Name and Address AYMOND FOR A PLATA	ss of Facility	SERVICE	LEXANDRI	A,VA.			
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):										
76(dicai Examiner	d										
, P.O. Box 687 that the death certificate ed by the attending phy detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	12 months? 4 Pregnant at time of death 5 Other (specify) Other (specify)									
Cords, P.	þ	Part II. Other significant conditions (contributing to death but no	ot resulting in the	underlying cause gr	ven in Part I.		eaccoluse contribute to	o the cause of death?			
Vital Reccional The law receptificate has be rector, page 2 short	Completed					-	<u> </u>	ned? death? No 1 ☐ Yes	utopsy findings available completion of cause of			
of Vita Physiclen: r this certific	To Be	25. Was case reterred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpate		4 Nursing no		nce 6 Other (Spe	cify)			
Division of Vital Records, P.O. Box 68 To the Hospitel or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Certification;	1 Natural 5 Pending investigatio 3 Suicide 4 Homicide 5 Pending investigatio 4 determined	9 Oce Blees of leiter	At home, farm,	/ M 1□	Yes 2 □No	28f. Location (Sti City or Town	reet and Number or R n, State)	ural Route Number,			
the Hospite thin 24 hours the Funera	Medical C		nysician: To the best of miner: On the basis of exa and manner stated.	amination and/or		ppinion, death occurr	red at the time, da		e to the cause(s)			
T W V		90. Signature and time of certified and signature and address of person who	Completed cause of death	N MC (Item 23a) (Typ	1			_	7 D Q0735			
Sta		EUZABETH K. 31. Date filed (Month, Day, Year)	32. Registrar's	1503 Signature	SURFA	tes kor	TV CU	ncon Mi	V 20735			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 06 35 M Janet 2007 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner TENINSUM REGIONA Salisbur Medical Hicomics Confu If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 📉 7/4/1923 Virginia Director 83 223-26-2154 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ ... any injury or other traumatic ever 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 X Yes 2 No Director Pocomoke City MD Worcester 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21851 601 Homewood Drive USA Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ∏ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XNo Specify: Completed by 3 Widowed 4 □ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farm Equipment 12 Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Earl S. Bloxom ဥ Edna Parks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Winter Quarters Dr., P.O. Box 234, Pocomoke, MD Bonnie Guy Powell (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/3/2007 Pocomoke City, MD 4 ☐ Donation 5 ☐ Other (Specify) First Baptist Cemetery 22. Name and Address of Facility, Holloway Funeral Home, P.A. 21. Signature of Fungal Service Licensee 103 Linden Ave., Pocomoke City, MD 21851 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** End Stage disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner U Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed her peti (and the burial-trai Due to (or as a consequence of): P.O. Box 68760, attending physician sepsis Physician/Medical use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records. s been signe should be d Completed by 4 Unknown 1 Yes 2 No 3 Probably 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of page 2 death? this certificate 2□ No 21 Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 50 NO 1 ☐ Yes Numpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death Natural 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? or Attending After Division (Month, Day 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident filled in by the after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of cert o completed cause of death (Item 23a) (Type, Print) Shone rastern

Registrar

State

(Month, Day,

Year

32. Registrar's Signature

JUN 0 5 2007

		1 - State Amend #5, perFH, G	State of Mary 368, 6/21/07	land / Depa	artment o	f Health a	nd Mental Hy	giene Reg. No. 2	7 19568		
Physic /Medi		1. Decedent's Name (First, Middle, Last) MARY E. HUFF					2. Date of De. Month JUNE	10 200	7 10:10a ^M		
Exami		4a. Facifity Name (If not institution, give s 129 Center Stre	et		Ceci	n, or Location of 1 ton ear If Under 2:	ton Cecil				
Funeral Director		5. Social Security Number 220-32-3995 Usuaf Residence of Decedent	N 087 F	n yrs. last birthday) 5 7 Yrs.		ays Hours	Min. (Month, Da	y, Year)	country) ryland		
Maryland	ctor	10a. State 10b. County MD Cecil	Cecilto				,	10d. Inside City Limits 1 XYes 2 □ No			
with th	Dire	10e. Street and Number 129 Center ST.			101. Zip Cod		10g. Citizen of What Country?				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "neturel", or Iteme 23a or 28s-1 ehow any Injury or other traumatic event, the Modical Examinar must be notified at Apple.	by Funeral Director		12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	☐ Yes 2 XNo Yes, Give 1 ☐ Yes 2XNo Specify:				U.S.A. 14. Race - A. Bfack, W Specify: W			
od within 72 hours aff giene. er than "neturel", or i, the Madical Exercit	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation	(Give		lone during most etired)	of working	16b. Kind of Busine	•		
be filed w ntal Hygier od other ti	Be	12 17. Father's Name (First, Middle, Last) John Getshall		HO	nemake	18. Mother	's Name (First, Middle		me		
nd 2 should be file lih and Mental Hy 27 is marked other traumatic event	2	19a. Informant's Name/Relationship (Type Edward L. Huffe				treet and Number	or Rural Route Numb	er, City or Town, State			
Definition of Health Indicate the Stand Indicate the Indicate		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		nusband) 20b. Place of Dispo cometery, cre Galena	osition (Name of matory or other	of r place)	517 Cecil Date 5/14/07	20c. Location - City Galena	or Town, State		
permit. P Departme Importan any Injury 2004.		21. Signature: Funeral Service Lineral	7 0/	_/					L. Schaecl 21635		
Utilizate be executed By physician and physician as the purial-transit	dicai Examiner	23a. Parti. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of): a consequence of): g n a n	Vec	ast VVC /euva	ardiac or respiratory a	LUSION	Approximate Interval Between Onset and Death O		
death cert e attendin	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 (4 Pregnant at ting 9 Unknown	Fetal death 3	□Ectopic pregr □ Other (specil			23d. Date of Month	delivery Day Year		
law requires that the as been signed by the 2 should be detached.	b V	Part II. Other significant conditions con	ntributing to death but r	not resulting in the (undertying caus	se given in Part I.		_/	e to the cause of death?] Probably 4 □Unknown		
The ate h page	Completed							ormed? prior death			
Physiclan: this certific ral director,	Be	25. Was case referred to medical examiner? 1 Yes 2 M6	Hospital:	2 ER/Outpatie	ent 3 DOA	Othor	of Death (Check only sing Home 5		Engarity)		
2 & <u>f</u> g	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y			Injury at Work?	28d. Describe	how injury occurred	pecity		
al or Attending s after death. In Director: Afte ad in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of friury building, etc.	- At home, farm, s (Specify)	treet, factory, or	ffice		(Street and Number o. own, State)	r Rural Route Number,		
he Hospil n 24 hour he Funera	edicai		sician: To the best of ones. On the basis of each manner state	xamination and/or is				, date and place, and	due to the cause(s)		
To t To t	Σ	29b. Signature and title of certifier	1	29d. Date signed (M	ionth, Day, Year)						
4		30. Name and address of person who con Barbara A. Pa:				1) 91 1 St. F	lkton, MI	<i>O /o</i> D. 21921	201		
Si Regis	tate trar	31. Date filed (Month, Day, Year) JUN 1 8 2007									

DHMH 17 Rev 1/2001

tamon	Μ	Hernandez-Paz	
-------	---	---------------	--

imon M Herna		2-Fa2 State Registrar 1. Decedent's Name (First, Middle,	e of Maryla		rtment of tificate of		and	Mental		Reg. I	No. 21	00	3. Time of Death	56
Physicia edical Exami		Ramon Martir H		Paz					Mont				1541 hrs	
1		4a. Facility Name (if not institution, Malcolm Grow Hospital	give street and num	nber)	41	city, Tow Camp S			eath		4c. County of Death Prince George's			
Funeral Director			Sex 7	7. Age (In yrs. Ia		If Under 1 Months	Year Days	If Under 24 Hours	A.dim	te of Birth(N	1	Foreign	place (State or E1 ^{htry)} Sa1vado	or
id how any ee.		Usual Residence of Decedent 10a. State 10b. County D • C •	10c. City,	oc. City, Town or Location Washington								10d. Inside City Lin	mits	
h the Maryland 3a or 28a-f show	Director	10e. Street and Number				10f. Zip Co	0f. Zip Code 10g. Citizen of What 0				at Count	ry?		
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. T's marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	Funeral D	10.3 Longfellow 11. Marital Status 1 Never Married 2 X Marr	12. Was Dece	dent Ever in U.	If Ye	s, specify C	Cuban, N	nic Origin? ⁄lexican, Pu	(Specify Ye lerto Rican, e	etc.)	E1 Sa1	- Americ	or an Indian, Black,	
72 hours after "natural", o	ρ	3 Widowed 4 Divor 15. Decedent's Education (Specific Elementary/Secondary (0-12)	ced If Yes, Give Year or Dates: y only highest grade College (1-		16a. Decedent	Yes 2 No specify:Salvadoran nt's Usual Occupation (Give kind of work done nost of working life. DO NOT use retired)				Specify: 6b. Kind of Bus				
5-0036 led within 72 Hygiene. other than '	Completed	12th 17. Father's Name (First, Middle, L	act)			Plı	umbe		lame (First N		Self I	Emp 1	oyed	
21215-00 uld be filed wit Mental Hygien marked other	Be	Valeriano Herna	ndez					Blan	ca E.	Paz	<i>'</i>			
e, MD 21 I and 2 should I Health and Mer iten 27 is mar	۲	19a. Informant's Name/Relationship Gladys Hernande	ingto	dress (Street and Number or Rural Route Number, City or Town, State, Zip Code) ngfellow Street, N.W. gton, D.C. 20011										
altimore, mit. Pages I an partment of Heal portant: If iten ury or other tra		20a. Method of Disposition 1 X Burial 2 Cremation		m State	Place of Disposit crematory or other	er place)		· ·	Date 06-08-	- 1	El Sal	•		
Baltimore, MD 2121! permit. Pages I and 2 should be fill Department of Health and Mental! Important: If iten 27 is marked injury or other traumatic event. It	3	4 Donation 5 Other Special Signature of Funeral Service Li		an C.C.	201	ame and Ad	idress o				Funera:	l Ho	me, Inc.	— ი
Physician /Medical xaminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Between Or Deat								Approximate Inte Between Onset a Death					
T #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last	Due to (or as a	<u> </u>										
50, te be execute hysician and burial - trans		UNPENDED	dAMENDED											
ox 6870 ath certifica attending plor use as the	ysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkn	3 [Ectopic pr	regnancy		23d. Date of Month		ay Year					
r, P.O. Be ires that the de signed by the be detached fi	by Phy	Part II. Other significant conditio	ns contributing to	F-5-7-11-	resulting in the ur	nderlying ca	ause giv	en in Part I			acco use contri		he cause of death?	
Records, The law requir ficate has been s	Completed								- _	a. Was an autopsy perform	ed? d		opsy findings avail ompletion of cause s 2 No	e of
Vital Re hysician: The this certificate I director, page	To Be (25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 lr	npatient 2 🗸	ER/Outpatient			thor:	neck only one lursing Home		esidence 6	Other:		
ion of tending Pl eath. tor: After the funeral		27. Manner of Death 1 Natural 5 Pendir 2 Accident Investi		of Injury Day,Year))07	28b. Time of In 1444 hrs	` <i>,</i>	1 Ye	at Work?	Drive	r of tru	w injury occum uck impa		h truck ar	nd
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	Certification:	3 Suicide 6 Could determ	not be 28e. Place		iome, farm, stree id / Highway				28f. Lo or Melwo	cation (Str Town, Stat od Road a	eet and Numbe te) at Old Marlbo	er or Rur oro Pike	al Route Number, e, Upper Marlbor	City ro, M
To the Hospital within 24 hours To the Funeral completely filled	ledical	one) 2 Medical Exam	rsician: To the besiner:On the basis of and manner st	f examination a		on, in my o	pinion, o	death occur						_
->	Ä	29b. Signature and title of certifier	melthe	le			License D.C.M				29d. Date sign June 2, 200		ith, Day, Year)	
2 (3)		30. Name and add ess of person w Margarita Korell MD.	ho completed caus Assistant Med			enn Stree	et, Bal	timore, N	MD 21201					
S	tate	31. Date filed (Month, Day Year)	32. Re	gistrar's Signa	507									

DHMH 17 Rev 1/2001

ORIGINAL

Colvie

State of Maryland / Department of Health and Mental Hygiene

2	n		7	Barmin ti-	0	5	7
barra	Sec. of	1-sadi	ii .		-	1	d

		1- For State Certificate of Death	violitai i i	Re	g. No.	1 1901
Physicia	an/	Decedent's Name (First, Middle, Last)		2. Date of Death)	3. Time of Death
ledical Exami	ner	w. Harding		Month May 31, 20	007	1704 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Locat Prince George's Hospital Center Cheverly	ation of Death		4c. County of Deat Prince Georg	
Funeral		,	f Under 24Hrs.	8. Date of Birth	(MM/DD/YYYY) 9. Bi	
Director			Hours Min.	7	Forei	
		Usual Residence of Decedent			13,1371	- Hary Land
v any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Aaryland 28a-f show Lat once,	ō	MD Charles Waldorf				1 Yes 2 X No
Maryl 28a-	Director	10e. Street and Number 10f. Zip Code		10	g. Citizen of What Cou	untry?
th the Maryland 23a or 28a-f sho		4790 Kitty wake Court 20603			USA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shinjury or other traumatic event, the Medical Examiner must be notified at once	neral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic If Yes, specify Cuban, Mex			14. Race - Ame White, etc.	rican Indian, Black,
er dea	Fun	1 Yes 2 No		,	Uh	ite
irs aft ural"	l by	15 December 1 - Company 1 - Co		ork done	Specify: W11 16b. Kind of Business	
72 hou	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			Governm	
036 ithin in ne.	Jdu	12 Contractor		0	Contrac	_
5-0 led w Hygie othe		17. Father's Name (First, Middle, Last) 18.Mc	Nother's Name	(First, Middle, M	laiden Surname)	
21215-0036 und be filed within 7: Mental Hygiene. marked other than c event, the Medical	Be	Richard Harding, Jr. Su	ısan Ka	therine	Harding	
ore, MD 21215-0036 ss I and 2 should be filed within 72 of Health and Mental Hygiene. If item 27 is marked other than ' her traumafic event, the Medical	٦	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and				e, Zip Code)
and 2 ealth:		Dina Harding/Wife 4790 Kittywake (20a. Method of Disposition 20b. Place of Disposition (Name of cemeter)	Court,	Waldorf Date	MD 20603 20c. Location - City o	Town State
AOre ages Lant of H it: If it		1 X Burial 2 Cremation 3 Removal from State crematory or other place)			,	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumafit event, the Med		4 Donation 5 Other Specify: Maryland Veterans Co	Cem. 6/	7/07	Cheltenham	m,Maryland
Balt permit. Departi		M00945 AREHART-ECHO	HOLS FU	NERAL HO	OME, P.A.	2646
Physician	- 10	I 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, ຣັບດາ-	h-as cardiac oi	r respiratory arre	st, shock, or leart	Approximate Interval
/Medical	3 38	failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries				Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):				
	ī	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	nin	Cisease or injury that initiated				
sit sd	Examiner	events resulting in death) Last Due to (or as a consequence of):				
760, cate be executed physician and the burial - trans		d.				
760, cate be ex physician the burial	Medical	UNPENDED AMENDED				
		FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Eco	Ectopic pregna	ncy	23d. Date of deliver Month	Day Year
Box 68760 death certificate b he attending physical for use as the bu	sician	Pregnant at time of death 5 Other (Specify)				,
be deg	Phy	9 Onknown		Too State		
Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death certif Ł4 hours after death. Funeral Director: After this certificate has been signed by the attending tely filled in by the funeral director, page 2 should be detached for use as	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given i	ın Part I.		2 No. 3 Pro	bably 4 Unknown
rds, require been sig	eted			24a. Was a		utopsy findings available
of Vital Records, ng Physician: The law require. Wher this certificate has been simeral director, page 2 should the street of th	nple			autops	y prior to	completion of cause of
tal Rec	Comple			1 ✓ Yes 2		es 2 No
ital sician s certi	Be	25. Was case referred to medical 26. Place of De examiner?	Death (Check o		2 - 1111 - 2 - 2 - 2 - 2 - 2	
ing Physing Physical distribution	<u>۲</u>	1 V Yes 2 No I Impatient 2 ► ENOutpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at V			Residence 6 Othe	er:
on C	tion	1 Natural 5 Pending May 31, 2007 1556 hrs 1 Yes 2		motorcycle c		
Division tal or Attendi rs after death. al Director: /	fica	2 V Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building	ing, etc.	28f. Location (St	treet and Number or R	ural Route Number, City
Division Hospital or Attent 24 hours after death Funeral Director	Certification:	Suicide 6 Could not be determined (Specify) Local Street		or Town, St. Lexington Rd &	ate) & Middletown Rd., V	Valdorf, MD
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and	nd place, and	due to the cause	e(s) and manner as sta	ted.
To the Ho within 24 b To the Fur completely	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, deat and manner stated.	ath occurred at	t the time, date a	ind place, and due to t	ne cause(s)
	Σ	29b. Signature and title of certifier 29c. License num			29d. Date signed (Mo	onth, Day, Year)
		dolote Jeljus O.C.M.E.			June 1, 2007	
10.01		Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Balti	ltimore MC	21201		
1P 10 = 1	ate			7 2 12 0 1		
Regist		31. Date filed (Month, Day, Year) 4 2007 32. Sgistrar's Signature				

OCIVIE

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2007 June 2, 10:57 а м Cecelia Irene Stem Hinkel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Finksburg 1976 Carrollton Road If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 🕱 F 65 Director Jan 29, 1942 212-40-7242 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2 No Maryland Carroll Finksburg Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21048 USA 1976 Carrollton Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Labs Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Irene Caulford Lester Francis Stem ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1976 Carrollton Road, Finksburg, MD 21048 George L. Hinkel, husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 6/6/2007 Finksburg, MD Evergreen Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Sin ature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home usto K 91 Willis Street, Westminster, MD 21157 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pridhelion - Appearing **Physician** MEMSTATIC /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Y*e*s Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To s after dea... 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled in 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 118320 5 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 12 ROAS 10753 1-4113 Lotter ville mg C 2 John 2. Regitrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 5

DHMH 17 Rev 1/2001

Registrar

2007

Physician /Medical Examiner

use as the burial-tra

attending physician for use as the buria

ed by the a

cate has been signing page 2 should be

certificate Physician:

this

within 24 hours after death

To the Funeral Director:
completely filled in by the

Hospital or Attending

death.

Completed by

Be

Medical Certification: To

law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

þ

Completed

Be

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Examiner Physician/Medical IF FEMALE:

CKD

26 Place of Death (C

24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
heck only one)	

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

28a. Date of Injury (Month, Day Year)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 1. Natural 2 Accident

3 ☐ Suicide

4 ☐ Homicide

5 Pending investigation 6 ☐ Could not be determined

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number D 50996 29d. Date signed (Month, Day, Year) 6/8/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 Brown St. Chastortown MD 21620 Stoddard MD

Registrar

31. Date filed (Month



			For State Registrar	State of Maryland	-	ent of Health ate of Death		ntal Hygien Reg. N	2 U U .	7 1957
			Decedent's Name (First, Middle, La	ist)	• .			Date of Death		3. Time of Death
	Physici /Medic		Mary		Hawkii	25		6 2	ay Year 200	7 1645 M
	Examin		4a. Facility Name (If not institution, give	e street and number)	4b. Ci	ty, Town, or Location	of Death	4	c. County of Death	
- marke				pice at the Lo Sex 7. Age (In yrs. le		- (-) - 1		Date of Birth	Wilcom	rco pplace (State or Foreign
	Funeral Director			1 M 2 M F 93	Yrs. Month			(Month, Day, Yea	(r) 3 Co.	intry) 5. C.
	and w		Usual Residence of Decedent 10a, State 10b, County	10c. City	, Town or Location					10d. Inside City Limits
	Maryla f shore	ō	mal 11/07	1- 50	10 1	111				1 Dryes 2 No
	the Notifi	Funeral Director	10e. Street and Number	52+CF 1211	10f. 2	Zip Code		10g. 0	Citizen of What Cou	intry?
	h with	al D	4042 Marka	4 Street		1863			U.S.1.	2.
	ems a	ner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was Der	cedent of Hispanic O pecify Cuban, Mexic	origin? (Specify an, Puerto Ric	Yes or No- an, etc.)	14. Race - Amer Black, White	
20	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 23a-f show or other traumatic event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes				Specify: p	. 1.
3	2 hour atural cal Ex	ted k	15. Decedent's E	ducation	16a. Decedent's U	sual Occupation		16b.	Kind of Business/I	OCK ndustry
א ה	thin 7; e. an "n Medi	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give kind of life. DO NOT	work done during mo use retired)	ost of working	. 4.		
7	be filed within Ital Hygiene. d other than "event, the Mee	Con	12.46	Zyears	Cartific	d Nursin	Ng AS.	st. L	enaxh	Fill Hosp
	ould be fill Mental H arked oth atic even	Be	17. Father's Name (First, Middle, Last	1 ~		18. Moth	her's Name (Fi	irst, Middle, Maide	en Surname)	,
Ž	should I	2	19a. Informant's Name/Relationship	bur + raser	19h Mailing Addre	ess (Street and Numi	the-i	oute Number City	OF CIN	in Code)
2	nd 2 shouth and 27 is ma		C- 11- 1/	((daughter)	4042 M	10-6-15	1-0-1	. A . I ([240 1]	in - 1 216
Ę,	es 1 and 2 of Health fitem 27		20a. Method of Disposition	/ 20b. Pl	lace of Disposition (A	lame of prother place)	Date	20c.	Location - City or	Town, State
Dalillillo			1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci			adly Con	6-8-	02 66	inleston	5.0
<u>a</u>	permit. Pa Departmer Important: any Injury		21. Signature of Funeral Service Lice	паее		and Address of Faci	ility Ben	vie Sm	ith Fun	eral Home
_	20 5 5 6	_			1917	Isabella		c+, 5a	lisburge	md 2180;
			23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	. Do not enter the m	ode of dying, such a	as cardiac or re	espiratory arrest,	0.	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consequ	ice Righ	it Cereb	seal of	nfare	(10 days
	Examiner			. Con Book	- Color	ant	Perios	elixan	· s	
	- * -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ	ience of):		,			
	scuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C						
Ö,	cate be executed physician and the burial-transit		resulting in death) cast	Due to (or as a consequ	ience of):					
00/00	ficate physi s the	edical		d						
X	n certifi anding use a	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnar					23d. Date of deli	very
<u>.</u>	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months?	1 □Live birth 2 □ Fetal 4 □ Pregnan't at time of de 9 □ Unknown		pregnancy (specify)			Month	Day Year
٦	d by the	Phy	9 Unknown Part II. Other significant conditions		ulting in the underlyin	a cause given in Port		23a Did tahaaa	uso contributo to	the cause of death?
cords,	signe d be d	d by	advanced &	Hage al zh	rimer's I	Disease				bably 4 Unknowr
2	w requ been shoul	Completed	m. 04:00	A land D.	. T.	1		24a. Was an		topsy findings available
ב	he las e has age 2	dmc	C 7	2/ 200	mune			autopsy performed?	prior to c death?	ompletion of cause of
	lan: 7	Be C	25. Was case referred to medical	Hapetten	site.	26. Plac	ce of Death (C	1∐ Yes 2 ⊠ 1 heck only one)	No 1 □Yes	2 .⊠ No
>	hysic his ce I direc	To E	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient 3	DOA Other: 4 🗆 N	Nursing Home	5 Residence	6 ⊠ Other (Spec	in) Hospica
	Attending Physician: r death. ector: After this certific by the funeral director,		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		. Describe how in	jury occurred	•
201	death stor: /	icati	2 Accident investigation 3 Suicide 6 Could not be	De Jaco of injunt. At hor	M me farm street fact	1 ☐ Yes 2 ☐		Location (Street	and Number or Ru	ral Pouto Number
2	al or A after I Direct	Certification:	4 ☐ Homicide determined	building, etc. (Specify	()	ory, office	201.	City or Town, Sta	ate)	rai nodie Namber,
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as			hysician: To the best of my know miner: On the basis of examinat						
	the H hin 24 the F mplete	Medical	one)	and manner stated.		29c, License number				
	5 ¥ 5 8	-	29b. Signature and title of certifier	Ran .	7.0	D 2950			Oate signed (Month	
	100		30. Name and address of person who	completed cause of death (Item	23a) (Type Print)	VZTSC	<i></i>			2001
	5		GREGORIO M. B	· ·	, , ,, ,	(NABERR	Y DR.	SALISBU	RY, MID	21801
7	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signat					1.17	
H	Registi	-	JUN 0 4	2007	4 had	,				
DHi	MH 17 Rev 1/2	001		1	ORIGINA					
					UnidiNA	L.				

			1 - For State Registrar	,	Certin	ficate of	Death	,	Reg. No.	1 95/4
			1. Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Day Yea	3. Time of Death
	Physici /Medic		Martha An	na Hamps	hire			06	02 07	
3	Examir		4a. Facility Name (If not institution, give			b. City, Town, o	r Location of Death		4c. County of De	
			PENIASUM REGIONA	A MEGICAL C	enter !	54.	1156414			imico
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. I	N.	f Under 1 Year Ionths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th 9. E	Birthplace (State or Foreign Country)
ь	Director		217-14-0700	82	Yrs.			8/6/1		aryland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Locati	ion				10d. Inside City Limits
	sho sed at	ō								1 X Yes 2 □ No
	the A	Director	Maryland Wicomi 10e. Street and Number	co S	Salisbur	Y 10f. Zip Code			10g. Citizen of What	Country?
	a or	ä								oounity:
	ns 23	Funeral	229 Canal park D	12. Was Decedent Ever in U.	S. 13. Was	2180 s Decedent of F		ecify Yes or No	USA 14. Race - A	merican Indian,
	iner iner	표	1 □ Never Married 2 🙀 Ma <i>rri</i> ed	Armed Forces? 1 ☐ Yes 2 🗽 No	If Y	es, specify Cub	lispanic Origin? (Sp an, Mexican, Puert	Rican, etc.)	Black, W	
336	urs ar	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 🗆	Yes 2XINo	Specify:		Specify:	white
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Completed	15. Decedent's Edu	ucation	16a. Deceden	t's Usual Occup	ation		16b. Kind of Busine	ss/Industry e, Hampshire
215	e. an "r Med	ed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	NOT use retired	during most of world)	ang	Andrews S	
21	d wii	ĕ	12	_	Secre	tary/tr	easurer		Andrews	our veyors
	al Hygi I other vent, ti	Be (17. Father's Name (First, Middle, Last)					•	, Maiden Surname)	
Maryland	should be fi and Mental H s marked ot umatic ever	10	Wakeman Whayland				Bernice	e Haddoo	:k 	
ar	2 shc and is m		19a. Informant's Name/Relationship (7)						er, Cify or Town, State	
	and ealth m 27		Harold W. Hampsh						Salisbury	
ore	Pages 1 nent of H int: If iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I	20b. P	lace of Disposition emetery, cremate	on (Name of ory or other plac		Date	20c. Location - City	
Ë	Pag ment ant: ury		4 □ Donation 5 □ Other (Specify,		omico M Park		0,0,		Salisbury	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21 Signature of Euneral Service Licens	CFS6	22 H	olloway	Funeral	Home Pr	ofessional	Association
_	20 E # 9		David Ho	Crocomox		OT DITOM	mili na.	, parra	Dury, FID 2	1804
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ications that caused the death one cause on each line.	n. Do not enter t	he mode of dyir	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a (michia	· Wea	DV	Failur	Q.		Onset and Death
7	/Medical Examiner		resulting in death)	Due to (or as a consequ			Pailur			
	LAGIIIIICI		Sequentially list conditions,	b. Corenary		2	Miseure			
	sit ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence ot):					
	ecut and I-tran	хап	that initiated events resulting in death) Last	c Due to (or as a consequ	ience of).					
60,	be e) ician buria	高 日 日		bac to (or as a consequ	201100 01).					
68760,	icate be executed physician and s the burial-transit	Medical		d						
×	# o ĕ		IF FEMALE:	23c. If yes, outcome pf pregna	nev					
Box	atten for us	ian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3 □Ed	ctopic pregnanc ther <i>(specify)</i>	у		23d. Date of Month	Day Year
P.O.	the d	Physician/	1 ∐ Yes 2 ⊠ No 9 ∐ Unknown	9□Unknown	cati oldo	trier (speciny) _				
٦.	w requires that the death cer been signed by the attendir should be detached for use		Part II. Other significant conditions co	ontributing to death but not resu	ulting in the unde	erlying cause giv	ven in Part I.	23e. Did	tobacco use contribute	e to the cause of death?
ds	uires sign d be	Completed by	End STace	Rengi Dis	CVIC			10	Yes 2□No 3□	Probably 4 Honknown
202	- 0 =	ete	Myzer chilos					24a. Was	24h More	autonou findingo available
Re	The law ate has b	mp	1906 Sev. Chirle?	112016121 6				auto	psy prior death	autopsy findings available to completion of cause of
a	n: The							1□ Yes	2 No 1 □ Y	′es 2□No
Division or Vital Records,	sician: The law certificate has t irector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital: 1 Propatient 2 1	ED/0-1	3DDOA Oth	26. Place of Dea			
ō	Phy: r this	<u>۲</u>	27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b, Time of	2 DOV	4 🗆 Nursing A		idence 6 Other (5	Specify)
on	ding h. Afte fune	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Inju Wor M 1 □	rk? Yes 2∐No			
İS	Atten deat ctor y the	fica	3 Suicide 6 Could not be	20e. Place of injury - At no	me, farm, street	, factory, office		28f. Location (Street and Number or	Rural Route Number,
5	after after i Dire d in b	Certification:	4 ☐ Homicide determined	building, etc. (Specify	V)			City or To	wn, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.			/sician: To the best of my kno						
	ne Ho n 24 l ne Fui letely	edical		iner: On the basis of examina and manner stated.						
	Withir Comp	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (M	onth, Day, Year)
	N		1			0	MATIC		clali	1

Registrar DHMH 17 Rev 1/2001

State

106 Milhors

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUN 0 4 2007

			For State	State of Marylan	d / Department of h		ntal Hygiene	007 19575
			State Registrar 1. Decedent's Name (First, Middle, Lasi	7)	Certificate of		Reg. No. Date of Death	3. Time of Death
	Physicia /Medic		George	Me VIN	Heath	Jr.	Month 3 Day	07 11:30 A.M
	Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, o	or Location of Death	4c.	County of Death
L			New towne Ap. 5. Social Security Number 6 Se	$\frac{1}{1}$, $\frac{1}{1}$ 1	last birthday) If Under 1 Year	OKC I Under 24 Hrs. 8.	Date of Birth	9. Birthplace (State or Foreign
	Funeral Director			2 M 2 □ F 60	Yrs. Months Days	Hours Min.	Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
	pu k		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location			10d. Inside City Limits
	Maryla fied at	ţō	md Warre	sto- Pa	comok-	City		1 Yes 2 □ No
	or 28a	Funeral Director	10e. Street and Number	3 / 6/ 1/0	10f. Zip Code		10g. Citi	zen of What Country?
	ath wil	ral	E-4 Newton	une Apts.	218	73/	- V N-	U, J, A,
	fter de	Fune	11. Marital Status 1 ↑ Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No	If Yes, specify Cub	dispanic Origin? (Specify an, Mexican, Puerto Ric		14. Race - American Indian, Black, White, etc.
036	ral', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 DYNo	Specify:		Specify: Black
21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. The Hygiene 124 or 28a or 28a-f show marked other than "natural", or Iteme 23a or 28a-f show imatic event, It e Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation de <i>completed)</i>	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of working	16b. Ki	nd of Business/Industry
212	d withi giene.	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	Cement L	aucr	An	broic Bishop Coust
<u>B</u>	tal Hyg	Be	17. Father's Name (First, Middle, Last)	1, 6		18 Mother's Name (F	irst, Middle, Maiden	Sumame)
Maryland	should to nd Men marked umatic	^L	19a. Informant's Na e/Relationship (7	eath St.	19b. Mailing Address (Street	Lillie /	Nac Blumber City	Town State Zin Code)
	2 6 5 5		Clarence Heat	6 (Brother	P.O. Box 82	4 Prince	90	md. 21453
w	es 1 and 3 of Health fitem 27 r other tr		20a. Method of Disposition 1	20b. F	Place of Disposition (Name of cemetery, crematory or other pla	Date	A CONTRACTOR OF THE PERSON NAMED IN	ocation - City or Town, State
Ĕ	. Pages tment of I tant; If its jury or o		`4 ☐Donation 5 ☐Other (Specify	\sim \sim	accdonia Ma	Can 6-9-	07 W	estover, md.
Bai	permit. Pag Department Important; I any Injury o		21. Sign tun of uneral Service Licen	see	22. Name and Addre	ess of Facility Box	ie Smit	h for cral Home
			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	plications that caused the deat	th. Do not enter the mode of dy	ng, such as cardiac or re	espiratory arrest,	Approximate Interval Between
	nysician :		Immediate Cause (Final disease or condition	- 0	ACE RENA	C DISEA	se	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	1111111111			-
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	quence of):			
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	c				
,092	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consec	quence of):			
6876	w = w	edicai		d.				
Box (leath certifical attending phy I for use as th	In/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnant 1 Live birth 2 ☐ Feta		·v		23d. Date of delivery
о. В	ie deat the att hed for	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of c 9☐Unknown		,		Month Day Year
<u>.</u>	res that the de igned by the a be detached t	/ Ph	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlying cause gr	ven in Part I.	23e. Did tobacco u	use contribute to the cause of death?
Records,	w requires been sign should be	ed by					1 ☐ Yes 2	No 3 Probably 4 □Unknown
eco	2 2 2	Completed					24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u>د</u> ح	: The cate h : page						performed? 1 ☐ Yes 2 No	death? 1 🗆 Yes 🤉 🛠 No
N N	Physician: r this certifice ral director, I	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DOA	26. Place of Death (C her: 4 \sum Nursing Home		6 ∏Other (Specify)
n of	ng Phy ter this neral c	n: T	27. Manner of Death 1 XNatural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of linjury Wo		d. Describe how inju	
Sior	Attending ir death. ector: Afte by the fune	catic	2 Accident investigation 3 Suicide 6 Could not be		M 1	Yes 2 □ No	Lanation (Chanat or	nd Number or Rural Route Number,
5	5 5 # 6	Certification:	4 Homicide determined	building, etc. (Speci	ome, farm, street, factory, office (y)	201	City or Town, State	
	To the Hospital within 24 hours a To the Funeral Completely filled		29a. Certifier 1 Certifying Ph	ysician: To the best of my known	owledge, death occurred at the t	ime, date and place, and	due to the cause(s) and manner as stated. d place, and due to the cause(s)
	the Hin 24 the Fu	Medical	one)	and manner stated.		se number		te signed (Month, Day, Year)
È	5 × 5 × 5	-	29b. Signature and title of certifier	d, MD		62172	61	4 (2007
,	J92		30. Name and address of person who		m 23a) (Type, Print)			11.
	5				4 MARKET ST	POCOMORE	CITY ME	21851.
	Sta Registi		JUN 0 5 2	32. Begistrar's Sign	ature Sparle			

For State Registrar 1. Decedent's Name (First, Middle, Last)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

Physician
/Medical
Examiner

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

2007

The law requires that the death certificate be executed as the burial-transif and or Vital Records, P.O. Box 68760, attending physician for use as the buria ed by the a nis certificate has been signed by director, page 2 should be detach Physician: the funeral Division filled in by

NICOLE JACKSON

Month NICOLE DENEANE JACKSON P^{M} 6:00 JUNE 01 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS HOSPICE TIMONIUM BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye OCT 26, 1 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 X F 31 1975 MARYLAND 219-84-3844 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County fshow Is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Director MARYLAND HARFORD HAVRE DE GRACE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 130 VANCHERIE COURT 21078 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1X Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: BLACK ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) within 72 (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PRODUCTION WORKER CLOTHES MANUFACTURER 12 or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be t permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 Is marked any Injury or other traumatic ev ALEKO JACKSON AGNES MARTIN ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 130 VANCHERIE COURT, HAVRE DE GRACE, MARYLAND 21078 AGNES MOSLEY / MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State R.A. FERRIS & CO, INC 6/5/07 WEST CHESTER, PA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses LISA SCOTT FUNERAL HOME, P.A. 552 LEWIS STREET, HAVRE DE GRACE, cott coomo MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **SCLERODERMA** disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🛣 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2**7** No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6XOther (Specify) HOSPICE Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 24 hours after death. e Funeral Director: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 43720 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN

5 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** May 15, 2207 SUZANNE 2007 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Takoma Park Montgomery Washington Adventist Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) Social Security Number 6 Sex **Funeral** Hours Months Days Min. 1 ☐ M 2 🗶 F Yrs. 80 Haiti Director September 3,1926 213-29-8010 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event the Machinel. 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2**K** No Director Maryland Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20903 Haiti 9802 Braddock Road Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 2 No Specify Specify. þ Black. 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Octavius Jourdain Odansine Unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9802 Braddock Road, Silver Spring, Maryland Rose Raymond - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington Cemetery 5/26/2007 Adelphi, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Further disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ex. h line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Tyes 2 No 3 Probably 4XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 X No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 🖳 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit within 24 hours a

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4 Homicide

(Check only

29a. Certifier

one)

JUN 04



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D52326

28f. Location (Street and Number or Rural Route Number, City or Town, State)

May 15, 2007

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav **Physician** рм 9:20May 30 2007 Hattie Jane Purnell Jacobs /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Berlin If Under 1 Year Worcester 105 Ennis Lane Birthplece (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🕱 F Yrs 2, 89 1917 Maryland 213-05-3165 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other then "natural", or iteme 23e or 28a-f show traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 X No Director Maryland Worcester Berlin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 105 Ennis Lane 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ 3 X Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e filed within all Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 7th laborer Hotel/Motel 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hitant: If Item 27 te marked ott Be Charles Edward Purnell Blanche Predeaux 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary J. Jarmon/ daughter 9676 Honeysuckle RD - Berlin, Maryland 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pagi Department i Important: If eny injury or St. Paul UMC Cemet. | 06/05/2007 4 ☐ Donation 5 ☐ Other (Specify) Berlin, Maryland 22. Name and Address of Facility 1213 Jersey Road, Salisbury, MD 21. Signature of Funeral Service Licensee 10 JOLLEY MEMORIAL CHAPEL 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and s the burial-transit Due to (or as a consequence of): Physician/Medical igned by the attending p be detached for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔊 inknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an hes autopsy performed?

1 Yes 2 No tor: After this certific the funeral director, 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 1 ☐ Yes 2 SONo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Naturat 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl
To the Funerel Director:
completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 024986 6

Registrar DHMH 17 Rev 1/2001 md-21801

m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Riversibe

JUN 0 4 2007

560

31. Date filed (Month, Day, Year)

Or. Bloc Salisbun

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month I. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** ANN IRWIN KLOPP JUNE 11 2007 14:08 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY FROSTBURG VILLAGE NURSING CENTER FROSTBURG If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. ULY 1917 9. Birthplace (State or Foreign IOWA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 👿 F 89 Director 508-20-5653 Usual Residence of Decedent with the Maryland 10a. State MD County ALLEGANY 10c. City, Town or Location 10d. Inside City Limits in then "natural", or Itema 23a or 28a-f show the Medical Examiner must be notified at CUMBERLAND 1 Yes 2 □ No Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 10 N. LIBERTY STREET 21502 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene important: If Item 27 is marked other then "natural", or Itema 23a any Injury or other traumatic event, the Medical Examples 1988. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) STELLA F. COLLINS FLUCK EDWARD P. FLUCK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
WASHINGTON STREET, FROSTBURG, MD 21532 SHARON IRWIN DAUGHTER 20b. Place of Disposition (Name of 20a. Method of Disposition FROSTBURG MEMORIAL PARK 6-13-2007 FROSTBURG, MD 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) -60 W. MAIN STREET 22. Name and Address of Facility
SOWERS FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee FROSTBURG, MD 21532 Souch MO054) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Advanced Dementia End Stage one year /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed the attending physician and hed for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 this Director: After that in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation death. 2 No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a To the Funerel [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier wowedesten D00 55325 Jun 11, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 MD 48 Tary Terrace Frostburg MD 21532 WONSOCK SHIN Joseph 164 2. Registrar's Signature State JUN 1 8 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 10, 2007 9:40A June Ε. Lyons Oueen 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) SC Social Security Number 6. Sex Months 1 □ M 2 🖫 F 50 Aug.1,1956 250-06-3120 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XIYes 2 □ No Suitland PG 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20746 United States 4668 Kendrick Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Private Outreach Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Crossland Sally Lyons Ernest 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4668 Kendrick Suitland, Md. Loretha Daniel/friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State Riverdale Crematory 6/12/07 Riverdale, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, Md. 20746 Approximate Interval Between Onset and Death d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate

Physician /Medical Examiner

and

physician

Physician

/Medical

Examiner

10a. State

Md.

Director

Funeral

þ

Completed

Be (

2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

ase for detached

e To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

ical Examir	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cC O O O O O O O O O O O O O O O	andit uence of): Spatt	is M		
ysician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of continuous	al death 3 Ectopic	pregnancy (specify)		23d. Date of delivery Month Day Year
7	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	g cause given in Part I.	Sec. 11	co use contribute to the cause of death?
5	and Stark	renald	ispose	on dialy	O 1 ☐ Yes	2 No 3 Probably 4 ☐Unknow
omplete	Hepatitis				24a. Was an autopsy performed 1∐ Yes 2 Z	
٥	25. Was case referred to medical			26. Place of De	eath (Check only one)	
0	examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence	e 6 ☐Other (Specify)
ation: I	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how i	injury occurred
Certification	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fact fy)	tory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
dical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	yslcian: To the best of my kniner: On the basis of examinand manner stated.	owledge, death occurration and/or investigat	red at the time, date and plaction, in my opinion, death oc	ce, and due to the caus curred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
ĕ	29b. Signature and title of certifier			29c. License number	29d.	Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Mai

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m

32. Registrar's Signature

ORIGINAL

7600 Carroll Ave.,

Takoma Park, Md. 20912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JUNE JUNE Year **Physician** Walter William Lemmert 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagers town Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 21,1928 Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** 1∏M 2□F Days Hours 78Yrs. Director 214-28-6205 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f shov notified at 1 ☐ Yes 2 No **Funeral Director** Warfordsburg РΑ Fulton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be r 3644 Stoneybreak Road 17267 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates 1947–1950 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Machine Operator Parts Remanufacture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ Ada Bell Folk Jacob Lemmert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cametery, crematory or other place)

Road Warfordsburg, PA 17267

Date 20c. Location - City or Town, State Arlene Lemmert/Wife 20a. Method of Disposition permit. Pages
Department of H
Important: If ite
any Injury or of Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Black Oak Mennonite 106/06/07 Warfordsburg, PA 21. Signature of uneral Service 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Bilateral **Physician** prevdomanai disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Post operative Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Hickel Hernic remove burial-trai Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 2 Probably 4 Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu death. 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 038764

DHMH 17 Rev 1/2001

10

State Registrar 4

Sut 127

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. 2,646

31. Date filed (Month)

JUN 1 8 2007

Med-l

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Ida F. Lancaster 10:50 AM 2001 Mas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Lanham Doctors Community Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) . Social Security Number **Funeral** 1 □ M 2 F 451-42-8721 81 1925 Greenville, TX Director Oct. 14. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Examiner must be notified at 1 ☐ Yes 2\ No Director MD Prince Georges Temple Hills 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4805 Tamworth Court 20748 U. S. A. items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ō 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: Black If Yes, Give Year or Dates: 3 Widowed 4 Divorced "natural" event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Finance Supply Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be R. Bailey Lois Johnson or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau Theodore Lancaster - husband 4805 Tamworth Court, Temple Hills, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham_Vet. Cem. 6-6-07 Cheltenham, MD 22. Name and Address of Facility Bell & Johnson Funeral Home, PA 21. Signatur of Funera 6503 Old Branch Ave., Temple Hills, MD 20748 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Enter the disease, or complicate, or heart failure. List only on e Cause (Final NEUMON **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** MPHYSEMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Box 68760. Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) P.0. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, been signe should be Completed by 1- UPPER GASTROINTESTINAL BLEEDING 1 Yes 2 No 3 Probably 4 Unknown RENAL FAILURE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s EMENTIA CARDIOMYOPATH performed death? 1 ☐ Yes ISCHEMIC 2□ No 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 Yes 2 No 1 Pinpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation (Month, Day Year) 1 Natural death. 1 Yes 2 No 2 ☐ Accident Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar

ANCOSTER

31. Date filed (Month, Day, Year JUN 0 5 2007

29b. Signature and title of certifier

MUHAMMAD

ASHRAF, MD. 5711 SARVIS AVE, #100 RIVERDALE, MD20737 32. Registrar's Signatu

MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

MD0057800

29d. Date signed (Month, Day, Year)

	1	For State Registrar	State of Ma	ryland /	-	irtment <i>tificate</i>					iene	07	19583
		Decedent's Name (First, Middle, Last)								2. Date of Deat		Year	3. Time of Death
Physician /Medical	l	CHARLES ROY	MAY							JUNE		007	8:45p M
Examiner		a. Facility Name (If not institution, give s Union Hospita]				4b. City, 1 Elkt	on			_	4c. County	il	
Funeral Director		213-44-3233	7. Age	61	Yrs.	If Under Months	Days	If Under Hours	h Aim	8. Date of Birth Month, Day NOV 27	1945	9. Birthi Coul Ma	place (State or Foreign ntry) ryland
Ba-f show	11	sual Residence of Decedent Da. State 10b. County MD Cecil		10c. City, To									1 ☐ Yes 2X No
h with th		De. Street and Number 203 Sycamore Ro	١.			10f. Zip 21	921			'	0g. Citizen of 1		ntry?
be filed within 72 hours after death with the Maryland tal Hygiene. d other then "netural; or items 23s or 28s-f show event, the Medical Exactle at most be inclified at the Commission by Eurasia Director	2	1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 (\$200 Per 2 1) No. 11 Yes, Give Year or Dates:			Vas Deced I Yes, spec I □ Yes 2		spanic Ori n, Mexicar Specify:		ecify Yes or No- Rican, etc.)	Bla	e - Americk, White,	
d within 72 hours afgiene. er then "netural; or tre Medical Exercit	Completed	15. Decedent's Educ (Specify only highest grade	ation completed) College (1-4or 5		(Give life. L	lent's Usua kind of wor DO NOT us	k done di e retired)	u <i>ring</i> mos		ng	16b. Kind of B		,
000		7. Father's Name (First, Middle, Last)	1	· 1	Prod	ucti	on s			LST (First, Middle, I	Rocke		ie1
nd 2 should be file lith and Mental Hy 27 is marked oth r traumatic event	0 0	Frank Dial								Marie			
12 sho h and 7 is mu		9a. Informant's Name/Relationship (Ty) Yoria Bell (oo, Print) daughte:			-				1 No.			DE. 1972(
permit. Peges 1 and 2 should b Department of Health and Mente Important; if Item 27 is marked eny injury or other traumatic a 20ce.	2	Oa. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Dopartion 5 □ Other (Specify)	emoval from State	20b. Place	of Dispo	sition (Nam	e of ther place	9)	(Date	20c. Location	City or T	
permit. F Departme Importar eny injur	2	21. Sunt in a fune at Service Licensy	9/	400510) 22 G	alen	a Addres a Fi	s of Facili iner Cro	al E	Home of	Step ena.	hen MD.	L. Schaed
	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or mmediate Cause (Final disease or condition esulting in death) Sequentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury hat initiated events esulting in death) Last	e cause on each lir	e myo a consequence reutea a consequence trac	ce of):	0 0			cardiac	or respiratory arr	9951,		Approximate Interval Between Onset and Death
the death certifically the attending plushed for use as the ched for use as the ched for the che		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea	ath 3□	Ectopic pro				10		ate of deliverant	rery Day Year
quires that the de n signed by the a uld be deteched to	ה ^י	art II. Other significant conditions cor	tnbuting to death b	ut not resultin	g in the u	nderlying c	ause give	on in Part	I. 	23e. Did to		tribute to	the cause of death? bably 4 Unknown
The law requir	Completed									24a. Was a autops perfor 1 🗆 Yes	med?		opsy findings available omptetion of cause of 2 No
Physician: The Ithis certificete he al director, page	e 2	25. Was case referred to medical examiner? 1 Yes 2 A	ospital:	۰ ۵۵۶۵	·	nt 3121 DC	Othe			h (Check only or me 5 ☐ Resid		(6	4.3
nding Physiath.	ation: 10	27. Manner of Death 1 Alatural 5 Pending 2 Accident investigation	1 ☐ Inpatie 28a. Date of Inju (Month, Da		Outpatier b. Time of Injury		8c. Injury Work	4 🗆 🕦		28d. Describe h			ny)
To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of tnj building, et	ury - At home c. (Specify)	, farm, str	eet, factory	, office			28f. Location (S City or Tow		ber or Rui	ral Route Number,
n 24 hour n 24 hour he Funera		29a. Certifier 1 SCertifying Physics (Check only one) 1 Medical Exami		f examination									
To ti To ti comp	Σ ;	29b. Signature and title of certifier	-20					82	3		June		Day, Year) 2007
14+1		30. Name and address of person who co Jui-Chih Hsu,	M.D. 2	23 W.	Ма	in St	. E	lkto	on,	MD. 21	921		
State Registra	e Ir	31. Date filed (Month, Day, Year)	32 Aegistr	ar's Signature	SE	Sold of							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		1	For Stata Registrar	ate of Maryland		irtment of H <i>tificate of l</i>			giene	1958+
			Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day Year	3. Time of Death
	Physicia		James Willard Maco	mauchev				June	06, 2007	10:46 P M
	/Medic Examin		la. Fecility Name (If not institution, give street	t and number)		4b. City, Town, or	Location of Death		4c. County of Dea	ath
	Examin	ν ι	1 West Baltimore St.			Hagerst	own		Washing	ton
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bir (Month, Da	y, Year) C	rthplace (State or Foreign country)
	Director		220-42-5371 ¹\\$™	2 🗆 F	64 Yrs.	Worth's Days	110010	May 06.	1943 Cum	berland,MD
	ס	-	Usual Residence of Decedent		-					10d. Inside City Limits
	rylan how		10a. State 10b. County	10c. City	r, Town or Lo	cation				1 ☑ Yes 2 ☐ No
	e Ma	cto	MD Washington	n Ha	gersto				10g. Citizen of What C	Λ
	or 28)ire	10e. Street and Number			10f. Zip Code				outray :
	23a	Funeral Director	11 West Baltimore St			217			USA 14. Race - Arr	nencan Indian
	ems erms	Ine	11. Wallal States	Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, Wh	
ဓ္က	d within 72 hours after death with the Maryland jiene. Jiene. Then "natural", or Items 23e or 28e-f show It e Medical Examinating the notified at	by Fu	**	1 □ Yes 2 MNo If Yes, Give		1 ☐ Yes 2 🏋 No	Specify:		Specify:	White
Ö	ural		3 Widowed 4 Divorced	Year or Dates:	16a Decer	dent's Usual Occup	ation		16b. Kind of Busines	
Maryland 21215-0036	"nat	Completed	15. Decedent's Education (Specify only highest grade co	mpleted)	(Give	kind of work done DO NOT use retired	during most of work	king		
7	within 72 ene. than "nal	E	Elementary/Secondary (0-12)	College (1-4or 5+) 2	Cleri	ical			Federal Go	vernment
2	be filed with tal Hygiene. d other than event, to M		17. Father's Name (First, Middle, Last)		02021		18. Mother's Nam	e (First, Middle	, Maiden Sumame)	
an	ed la b	Be	George W. Maconaugh	201			Louise	Carmer	llnger	
2	d 2 should be th and Menta 7 is marked treumatic ev	ဥ	19a, Informant's Name/Relationship (Type,		19b. Maili	ng Address (Street			per, City or Town, State	Zip Code)
Σ	12 s h ar 7 is		Carmon Gordon/Siste		17001	Hoower 1	v Acres L	Janoook	Mn 21750	
	1 a Hea	1 3	20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of matory or other pla	y =1-1 -5 -1	Date	MD 21750 20c. Location - City of	or Town, State
و	e ° = 5		19 Burial 2 Cremation 3 Rem	oval from State	•	•	1	11/07	Hancock, N	TD:
Baltimore,	Department Department Important: any injury once.	1	4 Donation 5 Other (Specify) 21. Signature of Juneral Service Lines of	TA ITIL.		2. Name and Addre			t Main Stre	
Ba	permit. f Departm Importal any injur		TV () (Me	C	cove Fune			ncock, MD 21	
			23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of	ions that caused the deat	h. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory	arrest,	Approximate Interval Between
П			shock, or heart failure. List only one of Immediate Cause (Final)	ause on each line.	lio	le shis	ato	24	a ilune	Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq	wones of):	-		1		year wig
	Examiner			Due to for as a conseq		51	1)1'5	ord	e.	Severel You
		ا ق	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):					
	ted	Ë	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Hr	me	r la	h, de	nis	مكن	werd You
P	axecut and al-trar	Examine	that initiated events c resulting in death) Last	Due to (or as a conse	uence of):	1				C
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	L d							
89	flicate g phy as the	edic								
Box	eath certific attending p	Z	IF FEMALE: 23c. 23c.	If yes, outcome of pregnature 1 ☐ Live birth 2 ☐ Feta		⊒Ectopic pregnanc	v		23d. Date of d	delivery Day Year
	death a atte d for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of c		Other (specify)	,		Month	Day
P.0.	uires that the de signed by the a id be detached f	hys	9 Unknown	9 Unknown						
	s that ned t	y P	Part II. Other significant conditions contri	outing to death but not res	sulting in the	underlying cause gi	ven in Part I.			e to the cause of death?
rds	quire; n sig	p p						1]Yes 2□No 3□	Probably 4 Dunknown
Records,	w require been si should	Completed by						24a. Wa	s an 24b. Were	autopsy findings available to completion of cause of
Re	sicien: The law certificate has b irector, page 2 s	m						per 1 □ Yes	formed? death	es 2 Symbo
ā	in: T ificat or, pe	ပိ	25. Was case referred to medical				26. Place of Dea			
⋚	Physicien: this certific ral director,	m	augminor?	pital: 1 Inpatient 2	ER/Outpatie	ent 3 DOA	her: 4 Nursing H	lome 5 Ne	sidence 6 Other (S	pecify)
o	Phy or this sral d	. To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time		iry at	28d. Describe	how injury occurred	
Division of Vital	Attending r death. sctor: Afte by the fune	ţi	1 Accident 5 Pending investigation	(Month, Day 19al)	Injury		Yes 2 □ No			
isi	Atter dea octor	fica	3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, s	treet, lactory, office	2311-122-2	281. Location City or T	(Street and Number or own, State)	Rural Route Number,
S	al or afte I Dire	Certification:		-						
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier (Check only 2 Madical Examina	ian: To the best of my kn	owledge, dea	th occurred at the	ime, date and place	e, and due to th	e cause(s) and manner e, date and place, and	as stated. due to the cause(s)
	n 24 n 24 ne Fu	Medical	one)	and manner stated.					29d. Date signed (M	
	To the vithing To the comp	Σ	29b. Signature and title of pertifier				se number	3-		
) of Carling	(m)			3549	//	6.7	/
	1		30. Name and address of person who com	pleted cause of death (Ite	m 23a) (Type	Print)	200	Pric	- Hen	225 town
	b		TANVIR A.	PASITA	MIC) 1/2	101	ALL	1. 11 ag	111) 3171
		ate	31. Date liled (Month, Day, Year)	32. Registrar's Sign	nature	Nº o				112116
	Regist	rar	JUN 1 8 2007	Broken S.	HORA	San P				

		For State Registrar			rtificate of L		R	eg. No. 2007	1958
Physici		Decedent's Name (First, Middle, Last) SHIRLEY	MOSES				2. Date of Deat Month JUNE	3 2007	3. Time of Death 12:07p
Examir		4a. Facility Name (If not institution, give s			4b. City, Town, or			4c. County of Death	
Funeral		Holy Cross Hospita 5. Social Security Number 6. Sex		s. last birthday)	If Under 1 Year	SPRING If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Birth	place (State or Forei
Director	Ш		^{M 2} √2 F 78	Yrs.	Months Days	Hours Min.	Apr. 7,	1929 Guy	ana
> 11		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Lim
shoved at	ō	MD MONTGOME		TAKOMA					1 Yes 2 📉
28a- notifi	Director	10e. Street and Number			10f. Zip Code		1	log. Citizen of What Cou	intry?
23a ol st be	al D	7620 Maple Ave #:	336		2091	2		USA	*
er mu	Funeral	11, Marital Status	2. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp in, Mexican, Puert	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
or it	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 ∑No If Yes, Give Year or Dates:		1 □ Yes 2⊠ No	Specify:		Specify: B	lack
atural cal Ex	ed b	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual Occupa	ation		16b. Kind of Business/l	
n "ng Medic	Be Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give life. I	kind of work done on DO NOT use retired	during most of wor. ()	king		
/giene er tha t, the	Som	12th		Dom	estic			Self Empl	.oyed
Health and Mental Hygiene. em 27 is marked other than wher traumatic event, the Me	Be	17. Father's Name (First, Middle, Last)					_{te Bakke} te Bakke	Maiden Surname)	
and Mental H s marked ot umatic ever	L _O	Charles Haywood 19a. Informant's Name/Relationship (Ty,	ne Print)	19b. Mailir	ng Address (Street a			r, City or Town, State, Z	ip Code)
Ith an 27 is 1 traul		George Moses/Husba		7620	Maple Av ma Park,	e. #336			,
nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition	20b	. Place of Dispo	sition (Name of matory or other place		Date	20c. Location - City or	Town, State
nt: If		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	ashington	1	1-2007	Adelphi, M	D.
Department of Heal Important: If Item 2 any Injury or other once.		21. Signature of Funeral Service License	e la rell		2. Name and Address arshall s				. 1 1
		23a. Part1. Enter the disease, or complished, or heart failure. List only or	cations that caused the de	ath Do not en	217 9th S	t. N.W.	Washing or respiratory ar	ton, DC 200	Approximate
ysician Medical caminer		Immediate Cause (Final disease or condition resulting in death)	Atheroscel Due to (or as a cons	rotic C					Interval Betwee Onset and Cea
	Examiner	Sequentially list conditions, if the cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consi	equence of):					
hysician ar the burial-t	edical Ex	resulting in death) Last	Due to (or as a cons	equence of):					
signed by the attending physician and be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome pf preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	□Ectopic pregnancy □ Other (specify) _	/		23d. Date of deli Month	very Day Year
ned by deta	by Ph	Part II. Other significant conditions co	ntributing to death but not r	esulting in the u	inderlying cause giv	en in Part I.	23e. Did to	obacco use contribute to	the cause of deat
been signed by the should be detache	q pa	<u>Diabetes Mellitus</u>	, Chronic Re	nal Fai	lure,		1 🗆 \	res 2to No 3∏Pr	obably 4 Unk
has be	Completed	Multi Organ Dysfu	nction, Resp	iratory	and Card	liac	24a. Was autop	rmed? prior to death?	topsy findings ava completion of caus
certificate rector, pag	Be Co	Failure 25. Was case referred to medical				26. Place of Dea	1 Yes ath Check onl o		20110
di ≌.	To B	examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 🔀 Inpatient 2	☐ ER/Outpatie	nt 3□ DOA Oth	er: 4 Nursing F	fome 5 ☐ Resid	dence 6 □Other (Spe	cify)
	Ë	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time of Injury	Wor		28d. Describe h	now injury occurred	
within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - Al building, etc. (Spe	t home, farm, st ecify)		Yes 2 □ No	28f. Location (S City or Tox	Street and Number or Ru vn, State)	ıral Route Number
n 24 hours ne Funera netely fille	edical C	29a. Certifier 1 ☑ Certifying Phy (Check only one)	sician: To the best of my liner: On the basis of exame and manner stated.	knowledge, dea ination and/or ii	th occurred at the tinvestigation, in my	me, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and manner as date and place, and due	stated. e to the cause(s)
withir To th comp	₹	29b. Signature and title of certifier	sa familia	1	29c. Licens	se number		29d. Date signed (Mont	h, Day, Year)
-	1. 9	1 L. Huyar	nound	\vee	D53	367		June 3, 20	007
					1 230				
(1)		30. Name and address of person who c	ompleted cause of death (I		, Print)			ng, MD. 209	0.3

December Marker				For State Registrar	State of Marylar	-	artment o			nd M		giene Reg. No.	007	19585
Marie Elizabeth Morten Estantial Formation of Section Name of the standard pass cases are standard passed on the Section of Section Name of S					1)								Vone	3. Time of Death
## Facility Control (Control Action)				Marie E	lizabeth Mo	orten								5:30a. M
Turodot Source Bauturn Present Source Source Bauturn Present Source Source Bauturn Present Source Source Bauturn Present Source Source Bauturn Present Source Bauturn Present Source Bauturn Present Source Bauturn Present Source Bauturn Source Bautur	3			4a. Facility Name (If not institution, give	street and number)		4b. City, Tow	wn, or Loc	cation of	Death		4c. C	ounty of Death	
The second process of		Exami	٠.	12801 Hollins P	lace		Bow	ie				Pri	nce Ge	orges
District Company Com		Funeral				last birthday)					8. Date of Birt	h (Year)	9. Birth	place (State or Foreign
Uncompared the control of the cont				577 52 5116	□M 21 71	Yrs.	Months Di	ays n	lours	MIII.	09/16/1	935		
Physician Medical Examiner Physician Medical Examiner To go of the physics of t		D												
Physician Medical Examiner Physician Medical Examiner To go of the physics of t		how					cation							
Physician Medical Examiner Physician Medical Examiner To go of the physics of t		e Ma	cto	MD Prince	Georges	Rowie								
Physician Medical Examiner Physician Medical Examiner To go of the physics of t		th th	Jire	10e. Street and Number			10f. Zip Co	ode				10g. Citize	on of What Cou	intry?
Physician Medical Examiner Physician Medical Examiner To go of the physics of t		23a	ai	12801 Hollins Pla	ice									
Physician Medical Examiner Physician Medical Examiner To go of the physics of t		des	inei	11. Marital Status		I.S. 13.	Was Decedent	t of Hispai Cuban, N	nic Origi Jexican,	in? (Spe Puerto f	cify Yes or No- Rican, etc.)	. 14		
Physician Medical Examiner Physician Medical Examiner To go of the physics of t	9	or it	Ę,		If Yes, Give	ĺ							Specify: Bla	ack
Physician Medical Examiner Physician Medical Examiner To go of the physics of t	g	ural',	d b								-			
Physician Medical Examiner Physician Medical Examiner To go of the physics of t	Ϋ́	72 h	ete	15. Decedent's Ed (Specify only highest grad	ucation de <i>completed)</i>	(Give	kind of work d	done durin	n ng most i	of workir	ng	16b. Kind	of Business/i	ndustry
Physician Medical Examiner Physician Medical Examiner To go of the physics of t	12	of hear	m	Elementary/Secondary (0-12)								Da	aretes Ch	nan / Draininata
Physician Medical Examiner Physician Medical Examiner To go of the physics of t	2	iled v lygie ther nt, th		17 Father's Name (First Middle Last)	Zyears	Ве	auticia	-	Mother	's Name	/First. Middle.			lop/filvate
Physician Medical Examiner Physician Medical Examiner To go of the physics of t	anc.	t be find the find th	Be		van1 o								,	
Physician Medical Examiner Physician Medical Examiner To go of the physics of t	Ĕ	d Me d Me nark natic	은			10h Maili	na Addrass (Si					ar City or	Town State 7	in Code)
Physician Medical Examiner Physician Medical Examiner To go of the physics of t	Nai	12 st h an 7 is r traur	F 1				-							, р 0000)
Physician Medical Examiner Physician Medical Examiner To go of the physics of t	e,	1 and Healt em 2 ther			20b.	Place of Dispo	osition (Name o	of					ation - City or 1	Fown, State
Physician Medical Examiner Physician Medical Examiner To go of the physics of t	סַנ	in it		1 ☐ Burial 2 Cremation 3 ☐	Hemoval from State	-				n6 /n	5/2007	Lon	domor	Maryland
Physician Medical Examiner Physician Medical Examiner To go of the physics of t	語	rt. Partiner		2-/	110									
Physician Medical Examiner Physician Medical Examiner To go of the physics of t	Bal	Depa mpo my j		21. Signature of the state service cites	Marin				-					
Physician (Medical Examiner) The proposed state of the properties				23a Part 1 Friter the disease of contra	plications that caused the dea									Approximate
Column C			9. 1	shock, or headfailure. Sonly	one cause on each line.	- NO		-1.	- 5		Λ	DOM: DW	viere	Onset and Death
Sequentially list conditions Due to (or as a consequence of):				disease or contion resulting in death)	a. CHRONIC	OB	IRUC	TIVE	1	UL	NO ME	Y D	BEASE	75 YRS -
The following of the property					Due to (or as a conse	quence on:								
The following of the property			<u></u>	Sequentially list conditions,	b. Due to (or as a conse	guence of								
The following of the property	П	ted nsit	를	cause. Enter Underlying Cause (Disease or injury										
State Stat		al-tra	Xai	that initiated events	Due to (or as a conse	quence of):						-		
FFEMALE 23d. Date of delivery 23d. Date of deliv	99	siciar buri		L.	d									
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 31 Probably 4 Unknown 24a. Whas an autopsy performed of large performed large performed of large performed large pe	687	ficate p phy is the	edic		0.									
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 31 Probably 4 Unknown 24a. Whas an autopsy performed of large performed large performed of large performed large pe	×	certi nding use a	N.				_					23	3d. Date of deli	ivery
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 31 Probably 4 Unknown 24a. Whas an autopsy performed of large performed large performed of large performed large pe	ĕ	atter	Cia	in the past 1/2 months?									Month	Day Year
The state of the s	0	y th	lys		9□ Unknown									
Performed? Geath?		that		Part II. Other significant conditions c	ontributing to death but not re	sulting in the u	underlying caus	se given ir	in Part I.		23e. Did t	obacco us	e contribute to	the cause of death?
Performed? Geath?	ds	uires ald bu		HYPERTENSIO	Ü						10	Yes 2□]No 3 X Pr	obably 4 Unknown
Performed? Geath?	Ö	w rec	ete	ASTILMA							24a. Was	an	24b. Were au	topsy findings available
25. Was case referred to medical examiner? The state Stat	Re	he la has ge 2	直								perfo	rmed?	death?	
To the part of period of the perio	a			DE Mas sees referred to medical					0 Di	of Dooth		-/	1 L Yes	2 L No
To the part of period of the perio	⋚	Sicia	00	examiner?	Hospital:	TEP/Outpatio	nt 3 🗆 DOA	Other			5		Other (See	outs)
State State St	of			-		28b. Time o								ыу
29a. Certifier (Check only one) 29b. Signature and title dycertifier 29b. Signature and dide do the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title dycertifier 29b. Signature and title dycertifier 29b. Signature and didess of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filled (Month, Day, Year) 32. Registrar's Signature,	on	ding h. Afte fune	5			Injury				No				
29a. Certifier (Check only one) 29b. Signature and title dycertifier 29b. Signature and dide do the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title dycertifier 29b. Signature and title dycertifier 29b. Signature and didess of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filled (Month, Day, Year) 32. Registrar's Signature,	İSİ	dea dea	fica	3 ☐ Suicide 6 ☐ Could not be	286. Place of Injury - At	nome, farm, si	treet, factory, o	office					Number or Ru	ıral Route Number,
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title ovcerifier 29b. Signature and title ovcerifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELWOOD 5 - HOLAND, McD. GOOS LAW DOVER RD. CHOUNT, M.J. 20 185 31. Date filled (Month, Day, Year) 32. Registrar's Signature.			erti	4 Homicide	building, etc. (Spec	iry)					City or 10	wii, State)		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELVOS S-HOLAND, Mr.D. 6605 LAW DOVER RD. CHOVERLY, M.J. 20185 State 31. Date filled (Month, Day, Year) 32. Registrar's Signal Lev.		spits nours neral												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELVOS S-HOLAND, Mr.D. 6605 LAW DOVER RD. CHOVERLY, M.J. 20185 State 31. Date filled (Month, Day, Year) 32. Registrar's Signal Lev.		P Ho 124 f 10 Fu 10tely	dic			ation and/or in	nvestigation, in	my opinie	ion, deat	th occurr	ed at the time,	date and	piace, and due	to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELVOS S-HOLAND, Mr.D. 6605 LAW DOVER RD. CHOVERLY, M.J. 20185 State 31. Date filled (Month, Day, Year) 32. Registrar's Signal Lev.		To th Vithir To th	Me	29b. Signature and title of certifier	\cap		29c. L	License nu	umber			29d. Date	signed (Mont	h, Day, Year)
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature.		1		1 Advan	& MX		17)200	989	,		6	11/0	7
State 31. Date filed (Month, Day, Year) 32. Registrar's Signal to	Λ	(10)		30. Name and address of person who	completed cause of death (Ite	om 23a) (Type	, Print)		1),			1	200
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature,	14			ELWOOD S- HOI	CAND, M.D.	6605	- LAND	bove	足人	D. 1	CHAVE	RLY,	ald. 2	20185
				31. Date filed (Month, Day, Year)	32. Registrar's Sign	1340	-					1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** P^{M} JUNE 2007 BETTY MAEMOWDY 6:33 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOSPITAL MEMORIAL FREDERICK FREDERICK FREDERICK 8. Date of Birth (Month, Day, Year)
Dec. 27, 1937 9. Birthplace (State or Foreign Country)
MD If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min. 1 □ M 2 🕱 F 69 218-34-1371 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at 1X Yes 2 No Frederick Frederick Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 818 E. 16th St. 21701 Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 █XNo Specify: White ģ 3 ☐ Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens important: if item 27 is marked other the any injury or other traumatic event, the ones. the hospital lab technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blanche Louise Stevens Charles Atlee Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonita Michaels (Daughter) 619 Biggs Ave., Frederick, MD 21702 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 3 Removal from State Pleasant View Cem. 6/5/2007 N Bu at 2 Cremation Burkittsville, MD 4 🗆 🗖 5 ☐ Other (Sat 2DomaTaddre of Farity ompson Funeral Home P. O. Box 18, Middletown, MD 21769 cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Parts. Enter the disease, or complications that shock, or heart failure. List only one cause or Immediate Cause (Final disease or condition resulting in death) **Physician** 05 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Justian Light) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed for use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No autopsy

page 2 s

Maryland 21215-0036

Baltimore,

Box 68760

Ö

٦

Records,

or Vital I

Division

Completed Be Certification:

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Prector, After this certifica completely filled in by the funeral director, F.

25. Was case referred to medical examiner?

State

Registrar

1 🗌 Yes 27. Manner of Death 1 Natural
2 Accident 5 ☐ Pending investigation 6 ☐ Could not be 3 ☐ Suicide 4 Homicide 29a. Certifier 29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

D-1397/

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

nd/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Frederick, mD.

28d. Describe how injury occurred

29d. Date signed/(Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ed cause of death (Item 23a) (Type, Print) 30. Name address of person who co 9+h 300

1 Inpatient

Year

Date of Injury

(Month, Day

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			1 - State of Marylan Registrar		artment of H <i>tificate of L</i>		, 0	ene eg. No. o o o o -	
10	Physici	an	Decedent's Name (First, Middle, Last)			·	2. Date of Deatl	h C Vear	3. Time of Death
E	/Medic		Jerry D. Morgan				May 31	, 2007	9:22 A M
	Examin	er	4a. Facility Name (If not institution, give street and number) 431 Christopher Avenue, #24		4b. City, Town, or Gaither	Location of Death		4c. County of Dea	
5.	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 004−30−5553 1≅ M 2□F 74	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 31		thplace (State or Foreign ountry) Bine
	show ed at	or		, Town or Lo					10d. Inside City Limits 1 X Yes 2 □ No
	the A	rect	10e. Street and Number		10f. Zip Code		10	Og. Citizen of What Co	
	th with	al Di	431 Christopher Avenue, #24		20879		τ	Jnited Sta	tes
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumetic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 【 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U Armed Forces? 1 【 Yes 2 □ No 19!! Yes, Give Year or Dates: 19.) I –	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
9	2 hou	ted	15. Decedent's Education	16a. Deced	dent's Usual Occup	ation		16b. Kind of Business	
21215-0036	thin 7, re. an "n	Completed by	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done of DO NOT use retired	during most of work d)	ing	United St	ates
21	led wi lygien her th nt, the		J	Cle	erk	40 Malla table	(F)	Air Force	
Maryland	d be fi	Be C	17. Father's Name (<i>First, Middle, Last</i>) Charles W. Morgan			18. Mother's Name		faiden Surname)	
aryl	should and Me mark umetik	T ₀	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street	and Number or Rui	al Route Number,	City or Town, State,	Zip Code)
Ž,	and 2 salth a n 27 is		Eva. M. Morgan (Wife)	431 (Christoph	er Avenue			rg, MD 20879
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny Injury or other tra		20a. Method of Disposition 1 № Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	lace of Dispo emetery, crer crling t Ceffic	sition (Name of matory or other place on Nation etery	nal June	21, 207	20c. Location - City or Arlington,	Town, State
Balt	permit Depart Import eny inj		21. Signature of Funeral Service Crefise	10		Park Dr	ive, Gai	eral Home thersburg,	MD 20877
	Physician		23a. Part 1 Enterthe disease, or complications that caused the deat shoot, or hear falure. List only one cause on each line. Immediate Sause Sina Non-Hodgkin disease or condition			g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	/Medical Examiner	П	resulting in death) Due to (or as e conseq	uence of):					
	, %)	e	Sequentially list conditions, if env. leading to immediate b. Due to (or es e conseq	uence of):					
	outed id ansit	Examiner	Sequentially list conditions, if ency, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
30,	rificate be executed by physician and as the burial-transit	EX	resulting in death) Last Due to (or as a conseq	uence of):			F 5-		
68760,	icate t physic	edical	d						
P.O. Box (The law requires that the death certifin the has been signed by the attending tage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnat 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of do 9 □ Unknown	Ideath 3	Ectopic pregnancy Other (specify)	/		23d. Date of de Month	elivery Day Year
	uires that signed by d be deta	ρ	Part II. Other significant conditions contributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did tob		to the cause of death?
Sor	w requir s been si should	lete					24a. Was ar	24b. Were a	utopsy findings available
or Vital Records,		Completed	25. Was case referred to medical			00 8	autops perform 1□ Yes 2	ned? death? 2XNo 1 ☐ Ye	utopsy findings available completion of cause of
Ž		To Be	examiner? 1 Yes 2 XNo Hospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Othe	or	h <i>(Check only one</i>	ence 6 □Other (Spe	ecify)
	nding Phy th. :: After thi e funeral (27. Manner of Death 1 X Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	28b. Time of Injury	Worl			w injury occurred	July
Division	al or Atte s after des Il Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At h building, etc. (Specif		eet, factory, office		28f. Location (St. City or Town	reet and Number or Fi n, State)	Rural Route Number,
	To the Hospital or Attending Physical Within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral directors.	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kno and manner stated.	wledge, deatl tion and/or in	n occurred at the tir vestigation, in my o	me, date and place, ppinion, death occur	and due to the carred at the time, d	ause(s) and manner a ate and place, and du	is stated. te to the cause(s)
	To th Withir To th Comp	Me	29b. Signature and title of certifier	_	29c. Licens	e number	29	9d. Date signed (Mon	th, Day, Year)
7	41		1 Gos C SUF		D430	83	1	May 31, 20	07
			30. Name and address of person who completed cause of death (Iten George A. Sotos, M.D., 9707 Med	ical C		ve, Suite	e 300, Ro	ockville,	MD 20850
,	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signal 33. Date filed (Month, Day, Year)	ture	WES .				

				For State		State o	f Mary	yland	/ Depa	artmer <i>tificat</i>				1ental		0.0	A 40	100000
				Registrar 1. Decedent's Name (First, Midd.	o Last)					inicai	COIL	Jeani		2 Date	of Death	g. No.		3. Time of Death
		Physicia	an			. M-b-							:	Mont	h	Day	Year	
		/Medic		Jorge Alfredo 4a. Facility Name (If not institutio						4h City	Town or	Location	of Death	May	31,	2007	nty of Death	10:00pm ^M
	er.	Examin	er	•		eet and no	ilibor)				hesda		or Boatin				gomer	i7
	-	Formul	7	Suburban Hospi 5. Social Security Number	6. Sex		7. Age (I	n yrs. la:	st birthday)	If Unde	r 1 Year	If Under		8. Date (Mon	of Birth	1	9. Birth	place (State or Foreign
	ю	Funeral Director		None	1 🔀 1	M 2□F		72	Yrs.	Months	Days	Hours	Min.	Apr	th, Day,	1935	Chi	ntry)
				Usual Residence of Decedent									1					
		how at		10a. State 10b. County			10	oc. City,	Town or Lo	cation								10d. Inside City Limits
		e Ma-f s	cto	Maryland Montgo	mery			Pot	omac									1 ☐ Yes 2 ☑ No
		ith th or 28 e no	Director	10e. Street and Number						10f. Zi	Code				10	g. Citizen	of What Cou	ntry?
		23a ust b		11512 Regency							0854					Chile		
		tems tems	Funeral	11. Marital Status		2. Was Dec Armed Fo	orces?	er in U.S.	. 13. \	Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic O an, Mexica	ngin? (Sp an, Puerto	ecify Yes Rican, et	or No- c.)		Race - Ameri Black, White	
	36	s afte	by F	1 ☐ Never Married 2 ☑ Mai 3 ☐ Widowed 4 ☐ Divorced		1 ☐ Yes If Yes, Gi Year or D	ve			1 ∑ Yes	2□ No	Specify	Chil	020		Spe	ecify: Wh	ite
	8	hour tural al Ex		15. Decede			ales.		16a. Deced	dent's Usi	al Occup		CHIL	.ean		16b Kindo	f Business/Ir	
	<u>.</u>	in 72 i "na fedic	Set	(Specify only high	st grade	completed)		-4	(Give	kind of wo	ork done d	during mo d)	st of work	ting			nerica	*
	12	with iene. thar	Completed	Elementary/Secondary (0-12)		College (5-			Consi						H	lealth	orga	nization
	D	i Hyg other ent,	BeC	17. Father's Name (First, Middle	Last)							18. Moth	er's Nam	e (First, M	1iddle, N	faiden Suri	name)	
	<u>a</u>	fenta rked ric ev	ToB	Federico Pena	Cere	ceda						Me]	lita	Mohr	Sch	uler		
	ary	shou s ma		19a. Informant's Name/Relation	ship (Type	e. Print)			19b. Mailir	ng Addres	s (Street a	and Numb	ber or Rui	ral Route	Number,	City or To	wn, State, Zi	p Code)
	Σ	and 2 ealth n 27 i		Maria Angelica	Pena	a (S ₁	ouse								ac,	MD 20	0854	
	ore	of He of He fiten		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 □ ₽₀	moval from	State	20b. Pla cei	ace of Dispo metery, crei	sition (Na matory or	me of other plac	e) :		Date	1	20c. Locatio	on - City or T	own, State
	Ĕ	Pag ment ant: I		4 □ Donation 5 □ Other (Olato	Met	ropol:	Ltan	Crem	atory	7 6/2	2/07				Virginia
N	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee	10	1		122	2. Name a Eas	nd Addres t De	ss of Faci er Pa	iity De V ark T	ol F rive	uner	al Ho	ome	
D	_	<u></u>		Tobert X	M	101			Ga	aithe	rsbu	rg, N	1D 20	0877				
				23a. Part1. Enter the dispuse, of shock, or heart failure. Lis	r complications	ations at cause on	caused the each line.	e death.	Do not ent	ter the mo	de of dyin	ng, such a	s cardiac	or respira	tory arre	est,		Approximate Interval Between Onset and Death
4		Physician		Immediate Cause (Final disease or condition resulting in death)	a.	Pros	tate	Can	cer									11 Years
9		/Medical Examiner		resulting in death)		Due to	(or as a c	onseque	ence of):									
MB	152		<u>.</u>	Sequentially list conditions,	b.	Due to	(or as a c	oneogue	ance of):								_	
1		ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Dissase or injury that initiated events	<	Due to	(01 23 2 0	onseque	crioc ory.									
74		and al-trar	хаг	that initiated events resulting in death) Last	C.	Due to	(or as a c	onseque	ence of):						_			
0	8760	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	dical E															
	89	ificate g phy as the			u.													
) 0.	Box	nding use a	Ž	IF FEMALE: 23b. Was decedent pregnant	23	c. If yes, ou				7						23d.	Date of deli	/ery
Q	Ď.	death a atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		4☐Preg	birth 2 l nant at tin			⊒Ectopic≀ ⊒Other <i>(</i> s		/					Month	Day Year
CR	P.0	that the death certific ed by the attending p detached for use as	Completed by Physician/Me	9 🗆 Unknown		9∐Unkr	nown							_				
(3)	_	ss tha	Ϋ́	Part II. Other significant condit		-	death but r	not resul	ting in the u	nderlying	cause giv	en in Part	I.	23e	. Did tob	acco use	contribute to	the cause of death?
	ord	en siç ould b	ed	Acute Renal Fa	ilur	e									1 □ Y€	es 22L N	lo 3 Pro	bably 4 Unknown
9	Records,	The law requires the sate has been signed page 2 should be de	plet											24a	. Was a		4b. Were au	opsy findings available ompletion of cause of
9			ě											10	perform Yes 2	ned?	death?	2 □ No
7	Vital	stan: ertifica ctor,	Be	25. Was case referred to medic examiner?	-							26. Plac	ce of Dea	th (Check	only on	e)		
0	or/	hysle his o	2	1 ☐ Yes 2 🔀 No	H		Inpatient		R/Outpatie			4 🗆 ۱	lursing H				Other (Spec	ify)
10		Attending Physician: r death. ector: After this certific by the funeral director,	ë	27. Manner of Death 1 X Natural 5 ☐ Pend	ng	28a. Date (Moi	of Injury 10 of Injury 11 of Injury	(ear)	28b. Time o Injury		28c. Injur Wor			28d. Des	cribe ho	w injury oc	ccurred	
0	sio	death.	cati	2 ☐ Accident inves 3 ☐ Suicide 6 ☐ Could	igation not be			411		M		Yes 2	_No					
0	Division	a er death al er death Director: din by the	Certification:		nined	build	e of injury ding, etc. (Specify	ne, farm, st	reet, racto	гу, опісе			City	or Town	reet and N 1, State)	umber or Hu	ral Route Number,
ena		Hospital 24 hours a Funeral I		29a. Certifier 1 🔀 Certify	na Physi	ician: To th	e hest of i	my know	vledne deal	th occurre	d at the tir	me date :	and place	and due	to the c	ausa(s) an	d manner as	stated
9		the Hospital nin 24 hours a the Funeral I npletely filled	edical			er: On the		xaminati										to the cause(s)
4		To the Hospital or Attending Physician: within 24 hours all of death. To the Funeral Director: After this certific completely filled in by the funeral director.	Med	29b. Signature and title of certif	er					25	c. Licens	e number	•	_	2	9d. Date si	igned (Month	n, Day, Year)
		P S P O		· /XS	575	7-					D430	83				June	1, 20	07
	7	D		30. Name and address of perso	n who cor	npleted cal	se of dear	th (Item	23a) (Type.	Print)					1			
			6	George A. Soto							Driv	re #3	00,	Rockv	7111	e, MD	20850	
		Sta	ate	31. Date filed (Month, Day, Yea	-)				ure									
		Regist	rar	JUN 0 4	200	I.	1814	ري م	15 Party									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 7 Month Year **Physician** 3:20 AM thony MA 2001 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner to more Hopkins 5. Social Security Number In yrs. last birthday f Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age **Funeral** Months Days Min Hours 1 X M 2 □ F Director 65 Washington, D.C. 578-56-2924 March 23, 1942 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director Maryland Howard Columbia 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7322 Shady Glen Drive 21046 U.S.A. Funeral 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 **X**If Yes, Give
Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 No Specify: Specify Be Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Production Manager Food 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anthony R. Maley Yolanda Aquilino 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bonnie Maley - Wife 7322 Shady Glen Drive, Columbia, Maryland 21046 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once, 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cemetery 6/1/2007 Adelphi, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. udewa 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 8 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MONTHS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 d Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760. o. ٦

should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural" مه نامیسه

Baltimore, Maryland 21215-0036

"natural", or items 23a or 28a-f show dical Examiner must be notified at

: If Item 27 is marked other than "natu or other traumatic event, the Medical

sician and burial-tran

nse

Por

page 2

director

funeral

physician the as attending

Pages 1 and 2 should be f nent of Health and Mental I int: If Item 27 is marked of

law requires that the death certificate be executed Division or Vital Records,

signed by the a certificate Physiclan: this After 1 Hospital or Attending ospital c.
4 hours after dec.
---neral Director; Atte in 24 hours the Funeral Dires

within 2

State Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WAY BROAD

and manner stated

timore MD

31. Date filed (Month, Day, Year)

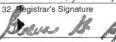
29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifier

JUN 04



07-04113

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Kevin R. McCarter Certificate of Death Reg. No 1- For State 3. Time of Death 2. Date of Death Registrar

1. Decedent's Name (First, Middle,Last) Month Day May 30, 2007 Physician/ 1920 hrs McCarter Medical Examiner Kevin c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Capitol Heights 195/495 at Ritchie Marlboro Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number oreign New York **Funeral** Hours Months Days 04/05/1958 49 $_{1}X_{M}$ Director Yrs 2 097-50-0822 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 No , or items 23a or 28a-f show must be notified at once. Fort Washington Prince George Maryland 10g. Citizen of What Country? Director 10f. Zip Code 10e. Street and Number USA 20744 413 River Bend Road Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Mantal Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married Armed Forces' 2X No Yes Specify: Black Yes 2 X No specify: If Yes, Give Year 4 Divorced after Widowed permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygeria. In important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done ş 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Cartert Mortgage Loan Officer MD 21215-0036 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) McCarter Marion Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 413 River Bend Rd. Ft. Washington, Maryland Wife LaTalia McCarter/ 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 6/9/2007 Buffalo, New York Forest Lawn Donation 5 Other Specify: 22. Name and Address of Facility Adams Funeral Home PA 21. Signature of Funeral Service Deersee 20605 Aquasco Rd. Aquasco, Maryland 191 Part Enter the disease, occomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line. Death 'Medical a. Multiple Injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit sician/Medical AMENDED UNPENDED The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Yea Dav 3 Ectopic pregnancy Month 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Phy contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions P.O. Yes 2 ✓ No 3 Probably 4 Unknown δ 24b. Were autopsy findings available Completed 24a. Was an Division of Vital Records, prior to completion of cause of autopsy death? performed? certificate has l 2 No 1 Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Other₄ Be Residence 6 V Other: Scene Hospital: 1 DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 this 1 🗸 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury 28b. Time of Injury Driver of auto involved in collision 27. Manner of Death After May 30, 2007 Certification: 1856 hrs Yes 2 V No Natural Pending Director: 28f. Location (Street and Number or Rural Route Number, City 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 195/495 at Ritchie Marlboro Road, Capitol Heights, Md. Could not be Suicide (Specify) Major Road / Highway determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 31, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Deputy Chief Medical Examiner Jack Titus MD. gistrar's Signatu 31. Date filed (Month, Day, State 2007

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

07-04170

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Harold Valentine Minner, Jr

2007 119592

		1- For State Registrar			C	ertific	ate of	Death				F	Reg. No.				
Physicia		Decedent's Name (First, Middl	e,Last)								2	. Date of De			3	. Time of Death	ì
ledical Exami		HADOLD WALESTE	INE MI	MARCO	TD							Month	Day	Year		0951 hrs	
roaldar Exami		HAROLD VALENT										June 1, 2			L		
		4a. Facility Name (if not institutio	-		nber)		48			ocation of	Death			ounty of [Death		
		524 Susquehanna Av	enue Api	t#6				Perryv	ille				Ced	cil			
Euparal		5. Social Security Number	6. Sex		7. Age (In y	's last hirt	hday)	If Under	1 Year	If Under	24Hrs	8 Date of B	irth/MM/DD	/YYYYY	3. Birth	place (State or	
Funeral		· ·				o. laot bii t	,	Months	_	Hours	Min.		(ÎF	oreign	_ ` _	
Director		222-32-4661	1 X M	2 F	58		Yrs.	Wortans	Duyo	110013	19811.	06-25	-1948	3	Cour	try) DELAW	ARE
		Usual Residence of Decedent							1	1			_				
<u> </u>		10a. State 10b. County			100 (ity Town	or Locatio								11	0d. Inside City	Limite
v any		Toa. State Tob. County			100.	alty, rown	OI LOCALIO	''							- 1		
p of	_	MARYLAND CECI	Ĺ.		PE	RRYV]	LLE								- 1	1 Yes 2	No
laryland 8a-f show at once.	욁	10e. Street and Number						10f. Zip (Codo.				10a. Citizer	of Mhat	Countr	3/2	$\overline{}$
Mar 28,	Director				"		- 1	•							Courin	у:	- 1
th the Maryland 23a or 28a-f sho notified at once.	اۃ	524 SUSQUEHANN	A AVEN	IUE A	PT #6			219	03				USA				1
rith 3 23	<u>.</u>	11. Marital Status	12 \	Nas Dece	edent Ever i	nus	13 Was	Deceden	t of Hisp:	anic Origi	n2 / Snec	cify Yes or N	o- T14	Race - A	America	n Indian, Black	
t Ed	unera	-		Armed For						Mexican,				White, e		ir molary black	' !
dea Illus	ا ج	, at the state of	1 🗴	Yes	2 N	0											
fer fer	7	3 Widowed 4 Div	orced If Yes	Give Year			1	res 2	N O	specify:			Sp	ecify:	1	WHITE	
urs a	by	15. Decedent's Education (Spe-	or Da		e completed) 16a.	Decedent's	S Usual O	ccupatio	n (Give ki	ind of wo	rk done	16b. Kind	d of Busin	ness/Ind	dustry	
Ex.	ompleted	Elementary/Secondary (0-12)		ollege (1-			during mo						15				- 4
6 g 2 G	<u>e</u>		1 ~	ollege (1-	40(5+)								1				1
5-0036 iled within 7/ Hygiene. I other than	Ē	12		0		5	SALES						SE	ARS			
5-0 led w tygic othe	ပ္ပ	17. Father's Name (First, Middle,	Last)						18	3.Mother's	Name (f	irst, Middle	Maiden Su	rname)			
215 be file ntal H rked c	Be (HAROLD VALENT	ING MI	MMED	CD					DADI	DADA	COLT					
21215-0036 uld be filed within 72 hou Mental Hygiene. marked other than "naf	0 13				DIV.	140	1.4.22					GOLT					_
ID 21215-00; should be filed with and Mental Hygiene 7 is marked other to natic event, the Men	ĭ	19a. Informant's Name/Relations	nip (Type, F	nnt)		191	o. Mailing	Address	(Street	and Numb	per or Ru	ral Route No	imber, City	or Iown,	State, 2	zip Code)	
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once		DEBORAH A. FAR	NIAK/	SIST	ER	1	303	WHITI	FIEL	D AVI	E., 1	OTHAN	, AL.	36	305		1
s I and 2 s'of Health au		20a. Method of Disposition			2		of Disposit					Date			ity or To	own, State	
MOFE, Pages 1 a nent of He ant: If ite		1 XBurial 2 Cremation	3 Re	moval fro	m State	cremat	ory or othe	er place)									
Pages nent of ant: If or other		4 Donation 5 Other St	pecify:			SHARO	N HI	LL MI	E PK	lo	06-08	3-2007	DOA	ER.	DEL.	AWARE	
Tight and St.		21. Signature of Funeral Service						me and A			-			OTUS			
Baltimore, ML permit Pages I and 2 s Department of Health an Important: If item 27 injury or other traum										,							001
		Thomas R.	la	der	_											WARE 19	
Physician		23a. Part I. Enter the disease, or			used the de	ath. Do no	ot enter the	mode of	dying, si	uch as ca	rdiac or r	espiratory a	rrest, shock	, or heart		Approximate Ir	
/Medical		failure. List only one cause	L.		ii o.a										- 1	Between Onse Death	et and
xaminer		Immediate Cause (Final disease or condition resulting in death)			juries						_				\rightarrow		
		or conductive suiting in death)	Due to	o (or as a	consequen	ce of):											
		Sequentially list conditions,	b												_		
	Examiner	if any, leading to immediate	Due to	o (or as a	consequen	ce of):											-
	를	cause. Enter Underlying Cause (Disease or injury that initiated	C.														
.=	ă	events resulting in death) Last	Due to	o (or as a	consequent	ce of):											
cuted ind transi			d.														-
0 10 ,	n/Medical	XUNPENDED		ENDED.					/	/	_		•				
760, cate be ex physician the burial	ਕੁੱ	_A ON ENDED	#2	3a,PI	I,27,28	Sa−f,	perME,	g869,	7/13	/07 T.	Γ						
8760, tificate be ng physic as the bur	ž	IF FEMALE:		c. If yes, o	utcome of p					_			23d. [Date of de	elivery		
as t	an l	23b. Was decedent pregnant in the past 12 months?	ne 1	Live bi		2	Feta	l death	3	Ectopic	pregnand	У	M	onth	Da	y Yea	ar
x 6 h cert tendir use a	:5		4	Pregna	ant at time o	f death		er (Specia					1				- 1
Box e death c the atten ed for us	ys	1 Yes 2 No 9 Uni	known g	Unkno	wn								- 1				
D.O. Box 6876 that the death certificate ned by the attending phy detached for use as the l	Physicia	Part II. Other significant condit	ions contr	ibuting to	death but n	ot resultin	a in the un	deriving	ause div	en in Par	11	23e. Did	tobacco use	e contribu	ite to th	e cause of dea	th?
P.O.	ģ			•			9	20,9	acco g		,			_	-		
P.C.	5	<u>Chronic alcoh</u>	<u>ol abus</u>	se								1 4	es Z _ r	NO 3	Proba	bly 4 🗸 Unki	nown
ds equi	Completed											24a. Wa	an I			psy findings av	
COT law r has b	효											auto			or to co: ath?	mpletion of cau	se of
Be he l	5												ormed? 2 No		/ Yes	2	No I
tal Rection: The certificate ector, page		25. Was case referred to medica	т —					26	Dinco	of Death (0	Chook on		لسنا	L		LI	
Cism Cal	Be	examiner?	Hospita	1.					10	Mari =			7	F			
of Vital Records, ng Physician: The law require. Wher this certificate has been signered in ector, page 2 should t	ပ	1 Yes 2 No	liospite	"'.1 In	patient 2	ER/O	utpatient	3 DC	A C	other4	Nursing	Home 5	Residenc	e 6 🗸	Other:	Scene	
fing Physi After this funeral dir		27. Manner of Death	2	Ba. Date of (Month)	of Injury	28b.	Time of In	ury 28	sc. Injury	at Work?	2	8d. Describe	how injury	occurred			
E if a Value	6	1 Natural 5 Pend	0			Ι.			1 Ye	es 2 XI	No.	, .					
Division tal or Attendi rs after death. af Director: //	ä		stigation L	nd 6/	1/2007	un	ĸ		, , ,	A		subjec					
in Pier Si	ı≗l		d not be	8e. Place	of Injury -	At home, fa	arm, street	, factory, o	office bui	ilding, etc	. 2			Number	or Rura	I Route Numbe	r, City
Divi	Certification:			(Specify)	othe	- rec	idence				5	or Town,	siaie) Jehanna	Δνα	6	Perryvil ¹	lo M
hou.		20a Cortifica															٠-, ١-
24 Fu	ल्ल	(Check only Certifying Pi															
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri.	ij	one) 2 ✓ Medical Exa	miner:On th	ne basis o nanner sta	t examinatio	on and/or i	nvestigatio	n, in my o	pinion, o	death occ	urred at t	ne time, dat	e and place	, and due	to the	cause(s)	
F 18 6	Medical	29b. Signature and title of certifie		name St	u.60.			29c.	License	number			29d. Da	te signed	(Mont	h, Day, Year)	-
	-	-7//		1	_											, = -9101/	
		(al ~il	(8/	/	()			1	O.C.M	ı.E.			June :	2, 2007			
		30. Name and address of person	who comple	eted cause	e of death (tem 23a)											
_			Assistant				11 Penr	Street	Baltin	nore M	ID 212	11					
							CIII	J ., C.C.,	Januil		.5 2 120						
		21 Data filed (Month Day Voor)		32/ Rec	gistrar's Sig	nature	A										
Si Regis	tate	31. Date filed (Month, Day, Year)	0007	10		25-0	R	- N									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** McGINNES 1335 FM HARRY 30, 200 / 4c. County of Death MAY /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner DORCHESTER MALLARD Bay Center Cambridge

If Under 1 Year | If Under 24 Hrs. |
Months Days Hours Min. Care 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 0 8 - 14 - Birthplace (State or Foreign Country) **Funeral** 10 M 2 F Year 222-09-8031 86 PENN. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Dover DE. Funeral Directo KeNT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? STREET 19901 USA 156 LOTUS 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: ₩₩ ፲፫ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Completed by Specify Specify: WhiTe 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION 8 Ó EQUIPMEN1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MEGINNES HARRY SOLNNER LINNIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) meG, NNES (SON) Lane, Cambridge, Md 21613 5506 MAllard 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Peges Depertment of Important: if it any injury or o 1 Burial 2 Cremation 3 Removal from State odd Fellows ConeTexy 6-5-2007 Canden Delaware 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility TRADER FUNERAL Home INC Thomas R. Tealer 12 LOTUS ST DOVER, Dal 18901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate **Physician** /Medical Medical Certification: To Be Completed by Physician/Medical Examiner

Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, signed by the a Id be detached fo should filled in by the funeral dire within 24 hours e

Peges 1 end 2 should be filed within 72 hours after deeth with the Marylend nent of Health and Mentel Hygiene.

Baltimore, Maryland 21215-0036

item 27 is marked other then "naturel", or items 23a or 28a-1 show other treumstic event, the Madical Examinar must be notified at

	snock, or near failure. List only or	16 cause on each line.			Interval Between Onset and Death
	Immediate Cause (Final disease or condition	Sposis			2 110065
	resulting in death)	Due to (or as a consequence of):			a wicks
	Sequentially list conditions,	Pheumo	niA		2 weeks
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	4		
	that initiated events resulting in death) Last	JAricell	4 Loster		7 0A45
	L a	Due to (or as a consequence of): Metha Cillan	Resistant Sta	oh Aurais Go	Willactivitys 3 weeks
	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregnancy		22	d. Date of delivery
	in the past 12 months?		topic pregnancy ther (specify)	250	Month Day Year
	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	itel (specify)		
	Part II. Other significant conditions con	ntributing to death but not resulting in the unde	rlying cause given in Part I.	23e. Did tobacco use	contribute to the cause of death?
	Atrial Fibrillati	ion, Coronary Antery	Disease Hype	THE SIOU Yes 201	No 3 Probably 4 Dinknown
	Neurogenic Blad	er Corvical Myelo,	outhy Chronic	24a. Was an	24b. Were autopsy findings available
	0 10- 00.	h / h	OHIMO CHIONIC	autopsy performed?	prior to completion of cause of death?
	25. Was case referred to medical	Wrastak Wisease Co	on junctivitis	1 Yes 2 1 1 1 1 0	1 ☐ Yes 2 🛇 🗸 🗸
	examiner?	fospital:	0.1	ath (Check only one)	
1	1 162 ZW NO	1 ☐ Inpatient 2 ☐ ER/Outpatient	3 DOA 4 Sorursing F	fome 5 Residence 6 □	
1	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury of	occurred
	2 Accident investigation		M 1 Yes 2 No		
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street and It City or Town, State)	Number or Rural Route Number,
	29a. Certifier 15 Certifying Phys	sician: To the best of my knowledge, death or		1	
	(Check only one) Medical Examin	ner: On the basis of examination and/or invest and manner stated.	tigation, in my opinion, death occu	ir, and due to the cause(s) and plurred at the time, date and pl	ace, and due to the cause(s)
1	29b. Signature and title of certifier	7 _	29c. License number	29d. Date s	signed (Month, Day, Year)
	1/ous a//	2 D.O.	H44615	5/3	31/07
	30. N = e a ro address of pers r o co	empleted cause of death (Item 23a) (Type, Prin	nt)		
1	V6013 A. / N	BR D.O. 100	Bromble 5	7 Camb	ridge MD 21613
	31. Date filed (Month, Day, Year)	Registrar's Signature		1,7,1,0	0

State

Registrar

JUN 1 1 2007

. Registrar's Signature

			1 - For State Registrar	State of	Marylar		artment of rtificate o				giene Reg. No.	097	19591
			1. Decedent's Name (First, Middle, La	ist)						2. Date of De	ath		3. Time of Death
	Physici /Medic		FLOYD	ELTON		MOORE				JUNE	Day 2	Year 2007	3:56 A ^M
	Examin		4a. Facility Name (If not institution, gir	e street and numb	er)		4b. City, Town	, or Location	of Death		4c. (County of Death	
			10501 SHINGLE L	ANDING RO	OAD			PVILL				WORCES	TER
П	Funeral			Sex 7. 1 ZXM 2 □ F		last birthday)	If Under 1 Yea Months Day		r 24 Hrs. Min.	(Month, Da	8. Date of Birth (Month, Day, Year)		place (State or Foreign htry)
	Director		220-32-8723 Usual Residence of Decedent		7	3 Yrs.				NOV. 15	5, 19	33 MA	RYLAND
	land		10a. State 10b. County		10c. Ci	y, Town or Lo	cation					1	Od. Inside City Limits
	Mary 4 sh	Ď	MARYLAND WORCE	STER		BISHO	PVILLE						1 ☐ Yes 2 No
	1 the	Director	10e. Street and Number			220110	10f. Zip Code				10g. Citiz	en of What Cour	ntry?
	3a o		10501 SHINGLE	LANDING I	CAOS		218	113				USA	
	death	Funeral	11. Marital Status	12. Was Decede	ent Ever in U	.S. 13.	Was Decedent of Yes, specify Co	f Hispanic O	rigin? (Sp	ecify Yes or No)- 1	4. Race - Americ	
ထ္	or He	F	1 ☐ Never Married 2 🕅 Married	1 X Yes 2	□ No		1 □ Yes 2 🛣 N			ricari, etc.)		Black, White,	
	Junel',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Date	s: 1954·	-56	10:03 200.1	o specii)	,. 			Specify: W	HITE
2	within 72 hours after death with the Maryland ene. than "neturel", or items 23e or 28e-f show fra Madical Exercities must be notified at	Completed	15. Decedent's E (Specify only highest gi			(Give	dent's Usual Occ kind of work dor	e during mo	st of work	ing	16b. Kin	d of Business/In	dustry
12	withir sne. than	mp	Elementary/Secondary (0-12)	College (1-4	or 5+)		<i>DO NDT</i> use <i>reti</i> FRUCK DF				ма	NUFACTU	DINC
2	Hygie ther int, in		17. Father's Name (First, Middle, Las	•)			IKUCK DI		ner's Name	First, Middle.			KING
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or liems 23s or 28s-1 show eumatic event, if a Madical Examinating mail to notified at	Be	CLAYTON	MOORE				ED		, ,	EBB	Jamano,	
<u></u>	should and Men a marke	70	19a. Informant's Name/Relationship			19b. Maili	ng Addrass (Stre					Town, State, Zip	Code)
Š	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		DOROTHY V. MOORE	/WIFE			•						MD 21813
ē,	s 1 a f Hea item othe		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other p	Ţ		Date		ation - City or To	
Ë	Page lent o nt: If ry or		1 🖾 Burial 2 ☐ Cremation 3 [`4 ☐ Donation 5 ☐ Other (Special Control of C		ate	-	N CEMETE		6/5/	0.7	BF	RLIN, M	ARVIAND
altimore,	permit. Pages 1 and 2 Depertment of Health a Importent: If item 27 is any injury or other tree		21. Signature of Funeral Service Lice	nsea	0		2. Name and Add			07		KLIIN, III	AKTHAND
Ö	80 5 8 8		Marley W	Hand	7	H	ASTINGS	FUNER.	AL HO	ME, SEI	LBYVI	LLE, DE	. 19975
			23a. Part1. Ehter the disease, or cor shock, or heart lailure. List only	plications that cau one cause on eac	see the deal	h. Do not en	Λ		s cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a. M	eth5	tatu	. Ur	un					Orisot and Death
	/Medical Examiner		resulting in death)	Due to for	as a consec	uence of):	1.1/						
		_	Sequentially list conditions,	b	as a consec	Chr	un						
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01	as a consec	derice or).							
	al-tra	xar	that initiated events resulting in death) Last	c. Due to (or	as a consec	uence of):	· · · · · · · · · · · · · · · · · · ·						
8760,	cate be executed physician and the burial-transit	dical	(d									
9	The law requires that the death certificate be executed te has been signed by the ettending physician and page 2 should be detached for use as the burial-transit	edi											
Вох	leath certific ettending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna		Ectopic pregnar	acv			2:	3d. Date of delive	
о. В	ed for	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		t at time of c		Other (specify)					Month	Day Year
<u>Ч</u>	w requires that the de been signed by the should be detached	Physician/Me	9 Unknown	7.00				r					
Ś	igned be d	Ď	Part II. Other significent conditions	contributing to dea	th but not res	ulting in the u	nderlying cause	given in Part	I.			. /	he cause of death?
Records,	requi	Completed								10,	Yes 2□	No 3 Prob	pably 4 □Unknown
ec	has b	npie								24a. Was autor	psy	24b. Were auto prior to co	ppsy findings available impletion of cause of
										1 Yes	2 No	death? 1 ☐ Yes	2□ No
Vital	ding Physician: The I h. After this certificate ha funeral director, page	Be	25. Was case referred to medical examiner?	Hospital:)thor		(Check only o			
ō	Phys this ral dii	<u>۲</u>	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 □ Inp		ER/Outpatie	I 3 DOA	4 🗆 N		me 5 Nesidesidesidesidesidesidesidesidesidesid		Other (Specif	(y)
0	ding h. Afte	tlon	t XNatural 5 ☐ Pending 2 ☐ Accident investigate	(Month,	Day Year)	Injury	W	ork? □Yes 2□	_	200. 5000.50	now injury	00001100	
Division of	l or Attenc after death Director: I in by the	fica	3 Suicide 6 Could not		Injury - At h	ome, farm, st	eet, lactory, offic					Number or Rura	al Route Number,
á	al or after	Certification:	4 Homicide	building	, etc. (Specil	(y)				City or To	wn, State)		
	To the Hospitel or Attending Physicien: within 24 hours after death of to the Funerel Director: After this certifical completely filled in by the funeral director.		29a. Certifier (Check only 2 Medical Exe	hysician: To the b	est of my kno	owledge, deat	n occurred at the	time, date a	ind place,	and due to the	cause(s)	and manner as s	tated.
	the F the F the F	Medicai	one)	and manne	r stated.				voculi				
	To with	<	29b. Signature and title of certifier	1 11	,	60	29c. Lice	nse number	30		29d. Date	signed (Month,	Jay, rear)
,	My.		7//	Jana	1	ロ・1ノ・		18/1	18		<i>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</i>	4-0	/
<	July		30. Name and address of person who	completed cause	death (Iter	n 23a) (Type,	314 FR	ANKL	111	VUE C	STP. 11	4 BEF	2112,4728
	Sta	te	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signa	ature /	, , , , ,			/	110-10	1/	1117 8
	Registr		JUN 0 4	2007		4	-						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** рм May 31, 2007 Nelson 5:00 Annette Gene /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Silver Spring Holy Cross Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year Months Days Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours 1 □ M 2 🕱 F Director March 22, 1925 Illinois 330-16-0212 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Maryland Silver Spring Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20901 9316 Colesville Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ŽŌ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Examiner once. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No SpecifyWhite Specify ģ Year or Dates: 3K Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Department Head County Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Blanche Callahan Charles Oscar Forstrom ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 318 Briarwick Court, Millersville, MD 21108 Sharon A. Borcz/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Noremation 3 ☐ Removal from State Alexandria, Virginia June 2007 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Chronic Costructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examine The law requires that the death certificate be executed Pneumonia and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 1∐ Yes 2X No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral of 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 5 | Pending 1 Natural 1 □ Yes 2 □ No investigation 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29e. license number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD030651700 June 1, 2007 4 30. Name and address of purson who completed cause of death (Item 23) (Type, Pr Hector Collison, M.D 106 Irving Street, NW, Washington, DC 20010 320 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

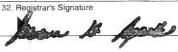
JUN 0 4 2007

State Registrar

Bennett

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



death.

washington St

Easton, MD 2160i

07-0 Мас

ıysicia Examii	an/	1. Decedent's Name (First, Middle,Last) MacGregor O'Brien	2. Date of Death Month Day Year June 11, 2007 3. Time of Death 1600 hrs							
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or 255 Talcott Avenue Frostburg								
neral ector		5. Social Security Number 392-56-2180 6. Sex 1 X M 2 F 57 Yrs. 6. Sex Months Days	Foreign							
items 23a or 28a-f show any ust be notified at once.	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code	10d. Inside City Limits 1 X Yes 2 No 10g. Citizen of What Country? U.S.A.							
ne. than "natural", or edical Examiner m	Completed by Funeral Di	Armed Forces? Never Married 2 X Married Armed Forces? If Yes, specify Cuban 1 Yes 2 X No 1 Yes 2 X	spanic Origin? (Specify Yes or Non, Mexican, Puerto Rican, etc.) specify: Specify: 14. Race - American Indian, Black, White, etc. Specify: White							
and Mental Hygier 7 is marked other natic event, the M	To Be C	Jorge O'Brien Clare MacGregor								
Department of Health a Important: If item 27 injury or other trauma		John K. Hurst 57 Frost	matory Cumberland, Maryl sof Facility Durst Funeral Home Ave., Frostburg, MD 21532							
sician edical niner	Examiner	23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
ned by the attending physician and detached for use as the burial - transit	Physician/Medical E	AMENDED AND AMENDED AND AMENDED AND AMENDED AND AND AND AND AND AND AMENDED AND AND AND AND AND AND AND	Ectopic pregnancy Month Day Year							
icate has been signed page 2 should be det	Completed by		1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No							
24 hours after death Funeral Director: After this certificate etely filled in by the funeral director, page	Medical Certification: To Be (examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death	or Town, State) 255 Talcott Ave, Frostburg, MD late and place, and due to the cause(s) and manner as stated.							
within 24 h To the Fur completely		and manner stated.	se number 29d. Date signed (Month, Day, Year)							

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Cei	rtificate of E	Death		Reg. No	.C. = 1		
	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	Da	y Year	3. Time of Death	
	/Medic	al	Norman Robert O'Brien		Ab City Town or	Location of Dooth	June	08	3 2007 . County of Deatl	8:59 P	
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			Caroline	1		
22			Caroline Home for Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last	hirthday)	Denton If Under 1 Year	If Under 24 Hrs.	8. Date of Bir				
نيوب	Funeral Director	y	216-56-0795 1 M 2 F 55 Usual Residence of Decedent	Yrs.	Months Days	Hours Min.	(Month, Da Aug 27	ay, Year)	951 Rho	nplace (State or Forei untry) de Island	
	aryland show dat	-	10a. State 10b. County 10c. City, T	own or Lo	ocation	_				10d. Inside City Limi	
	8a-f	ectc	7	estor	T			10 0	log. Citizen of What Country?		
	vith ti	Ö	10e. Street and Number		10f. Zip Code					untry?	
	s 23a	eral	3639 Choptank Road 11 Marital Status 12. Was Decedent Ever in U.S.	12	21655	anania Origina (Cn	ooifu Voo or Na	U.S.	A . 14. Race - Ame	ican Indian	
20	e filed within 72 hours after death with the Maryland al Hygiene. Alcher than "natural", or Items 23a or 28a-f show vent, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1		Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:				Black, White		
0000-017	2 hou latura ical E			16a. Dece	dent's Usual Occupa	ation	ina	16b. K	(ind of Business/		
2	thin 7 e. an "n Medi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life.	kind of work done d DO NOT use retired)	uring most of work	mg				
7	ed wil	6	**	maint	enance su	*		building industry			
yiaiid	tal Hid oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	,		,		
2	Men arke	ဥ	Joseph Michael O'Brien				Mildred				
2	2 sh and is m raum		, , ,		ng Address (Street a						
≤ 1\^	and lealth m 27 her t		Jessica A. Leininger/ daughter				EIK Pa		N.C. 2	8622	
Dalilliore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		IN Burial 21 (Cremation 31 Hemoval from State)		osition (Name of matory or other place Cemetery	06/1				Maryland	
Dal	permit. Departi Importa any Inj		21. Signature of Funeral Service Licensee		2. Name and Addres leegle and) Box; Gre		ein Fur Maryla	iera;	1 Home,	PA	
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one caute on, ach line. Immediate Cause (Final disease or condition resulting in death) Dut to (or as a consequent of the consequent of the cause of the c	Do not en	ter the mode of dying	g, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Chset and Death	
	Examiner	<u></u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence cause)							-	
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events C	100 01).							
,	exect n and ial-tra	Exa	resulting in death) Last C. Due to (or as a consequer								
00/00	rificate be executed ng physician and as the burial-transit	Medical	d	■ d							
	ertifica ing pl e as t	Med	IF FEMALE:					-			
O. Box	ne death ce the attendii thed for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			23d. Date of del Month	d. Date of delivery Month Day Year				
7.	w requires that the death cer been signed by the attendir should be detached for use	b	Part II. Other significant conditions contributing to death but not resulting	ng in the ι	underlying cause give	en in Part I.		tobacco Yes 2		the cause of death?	
Records,	sician: The law requires that the certificate has been signed by th rector, page 2 should be detache	Completed					_ per	opsy formed?	prior to death?	utopsy findings availa completion of cause of	
VII	(0 ===		25. Was case referred to medical			26. Place of Dea	1 Yes	one)	7 1 103	20110	
	ysici s cer direct	o Be	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatie	nt 3□ DOA Othe				6 □Other (Spe	cifv)	
on or	ding Phys h. After this funeral dii	tion: T	27. Manner of Death Natural 5 Pending (Month, Day Year) Accident investigation	8b. Time o Injury	Worf		28d. Describe			- 37	
LINISION	To the Hospital or Attending Physiciam: within 24 hours after dearh. To the Funeral Olrector After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home building, etc. (Specify)	e, farm, st	treet, factory, office		28f. Location City or To	(Street a own, Sta	and Number or Rite)	ural Route Number,	
	ne Hospital or A	Medical C	29a. Certifier (Check only one) (Check o	edge, dea n and/or i	th occurred at the tin nvestigation, in my o	ne, date and place pinion, death occu	, and due to th rred at the time	e cause(e, date a	s) and manner a nd place, and du	s stated. e to the cause(s)	
	To the within 2 To the complet	Me	29b. Sign ture and title of certifie		29c. License	e number	۾	29d. D	ate signed (Mont	th, Day, Year)	
			30. Name and address of person who completed acuse of death (Item 2:		1 0	61.	to		2 1	1 1167	
	Sta Regist		31. Date filed Month, Day, Year) JUN 12 2007	-/	6 12,	Ches	TC/ 1		~11, 10	(a riva	

DHMH 17 Rev 1/2001

Amend Items 4a,29d,30 per dr., g858,06/18/0/dhb Reg. No. 2. Date of Deeth 3. Time of Death
250pm 1. Decedent's Name (First, Middle, Last) Physician velyn ar /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (II not institution, give street and number)
Heritage Harbour Health & Rehab. Ctr. Annapolis Examiner Arundel Co. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | July 4, 1923 5. Social Security Number 189–16–4417 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Pennsylvania 1 M 200 F 83 Yrs. Director Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mentel Hyglene. Important: if item 27 is marked other than "naturs!, or items 23s or 28s-1 show any Injury or other traumatic event, the Medical Evanines must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Orbisonia Huntingdon XX Yes 2□No Pennsylvania Funeral Director 10g. Citizen of What Country? USA 10f. Zip Code 10e. Street and Number 17243 PO Box 274 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ※ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specifi White Be Completed by X3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Housekeeping Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) Currance James 17. Father's Name (First, Middle, Last) Thornton Rohrer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23965 Decorum Road, Neelyton PA 17239 19a. Informant's Name/Relationship (Type, Print) Park (Son) Robert 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State **Burial 2 Cremation 3 Removal from State 4/25/2007 Orbisonia, PA Orbisonia Cemetery 4 Donation 5 Other (Specify) M-0084922. Name and Address of Facility Lochstampfor Funeral Home, Inc. Te of Funeral Service Licenses 48 S. Church Street, Waynesboro, PA 17268 23a. Rart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical ecuana Examiner Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed the buriel-tren Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): end Division of Vital Records, P.O. Box 68760, ettending physician Due to (or as a consequence of) USe es 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. After this certificate has been signed by the funerel director, page 2 should be detached 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1 Li Yes WE NO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No Medical Certification: To 1 Yes efter death. Director: After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours e To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) completely and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie April 23, 2007 pleted cause of death (Item 23a) (Type, Print) 30. Name and address of son wh Aditya Chopra, MD, 600 Ridgley Ave., Suite 231, Annapolis, MD 21401 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

07-04056

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

\mathbb{Z}^{m_1}	0	- m	7	1	13	-	0
6.) -			-	Ų.	0

Shelby Wendell Pit		State of Maryland / Department of Health and Mental Hy For State Certificate of Death	ygien		N.	20	17 1950
	R	Decedent's Name (First, Middle,Last)	2. Date	Reg. of Death			3. Time of Death
Physician/ Medical Examine		Shelby Wendell Pittman	Mont May	n Da 28, 200	ay ` 7	Year	2056 hrs
Wei - I Lamine		a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death			4c. Cour	ity of Death	
,		Malcolm Grow Hospital Suitland				e George	
Funeral	5	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	s. 8. Da	te of Birth(MM/PB/Y	YYY) 9. Birth	place (State or
Director		579-94-3787 1X M 2 F 34 Yrs. Months Days Hours Min	Fe	bruar	y 10	Cou	Maryland
	Ļ	sual Residence of Decedent					
ŕ	_	0a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits
1 c w 3		Maryland Prince Georges Suitland					1 X Yes 2 No
the Maryland a or 28a-f sh tified at once	┋┝	De. Street and Number 10f. Zip Code		10g.	Citizen of	f What Coun	try?
or 28		3409 Southern Avenue 20746		FC	Unit	ed Sta	ites
t with the Maryland ms 23a or 28a-f show any be notified at once.		112 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	Specify Ye	es or No-			can Indian, Black,
r death with or items 23 must be no	≣	1 X Never Married 2 Married Armed Forces?	o Rican,	etc.)	\ \ \ \	Vhite, etc.	31ack
er de		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:			Spec	cify:	DIACK
ural"	<u></u> }⊦	or Dates: 162 Decedent's Usual Occupation (Give kind of	work do			of Business/I	
2 hou	ᇎ	Elementary/Secondary (0-12) College (1-4 or 5+)				-	of Commerce
bin 7 e. than edica	اَقِ	2 years Legal Instrument Exam					ade Office
d wit de Men	Completed	17. Father's Name (First, Middle, Last) 18. Mother's Nam					
215 se file se file tral H ked c	8	Hardy Bell Michaels Lydia					7: 0 1:
	9	9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or					
MD 2 she th and 27 is 27 is umat	١	Lydia Bell Pittman (Mother) 3409 Southern Avenue		itlar	id, M	ary Lar	Town, State
Heall Heall	Щ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July 18 19 19 19 19 19 19 19	Date ne 2	,200		North	Carolina
ages art of ut: If	Ш	1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: Evergreen Memorial Cemet			Grif	ton, I	Pitt County,
Itin nit. P artme ortar	t	ignaryre of Funeral Service Licensee 22. Name and Address of Facility. R. N. Horton Com		Mort	icia	ns. It	nc.
Ba Perm Depo Imp	4	1600 Kennedy Stree	et. N	I.W.:	Wash	ingto	1,D.C. 20011
Physician	1	23a. Part I. Enter the dil ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respi	ratory arres	st, shock, o	or heart	Approximate Interval Between Onset and
1edical	Į	failure. List only one cause on each line.					Death
aminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				<u> </u>	
		Sequentially list conditions, b					
	힏	if any, leading to immediate cause. Enter Underlying Cause					
	Examine	(Disease or injury that initiated					
ted 1 msit	ŭΙ	events resulting in death) Last Due to (or as a consequence or).					
0, e be executed ysician and burial - transit	edical	UNPENDED AMENDED					
00, te be ex ysician burial	edi	Long Many subserve of prognopoly			23d. D	ate of delive	гу
cords, P.O. Box 68760, law requires that the death certificate be has been signed by the attending physic 2 should be detached for use as the burner.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic preg	gnancy		Mo	nth	Day Year
× 6 h cer tendi	icia	4 Pregnant at time of death 5 Other (Specify)			ŀ		
Bo e deat	hys	1 Yes 2 No 9 Unknown 9 Unknown	711	23e. Did to	bacco use	contribute to	o the cause of death?
P.O. es that the igned by be detach	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	- 10				obably 4 Unknown
Tigner of the d			- 14	24a. Was a			autopsy findings available
rds requ	Completed		_	autop: perfor	sy	prior to death?	completion of cause of
e law ie has	ш		1	Yes :		1	
tal Recision: The certificate		25. Was case referred to medical 26.Place of Death (Cher	eck only o	ne)			
Vital ysician his cer	Be	examiner? Hospital: 1 Innatient 2 FR/Outpatient 3 DOA Other; Nur	rsing Ho	me 5	Residence	e 6 Oth	er:
n of Vital Records, ing Physician: The law require After this certificate has been structed director, page 2 should let	. To	1 ✓ Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d.	Describe h	now injury	occurred	ved in accident
On C tending eath. or: Af the fun	io	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) May 28, 2007 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 ✓ No					
IVISIOI or Attene after death Director:	icat	2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.		as Taura C	tata!		Rural Route Number, City
Division tal or Attendi rs after death. The Director: A led in by the fi	Certification:	3 Suicide 6 Could not be determined (Specify) Local Street	6800	or Town, S Block Pi	ckett Dri	ve, Morning	gside, MD
		4 Homicide 29a Certifier	and due	to the caus	e(s) and r	manner as st	ated.
the H iin 24 iplete	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	ed at the	time, date	and place	, and due to	the cause(s)
To the within To the complet	Med	29b. Signature and title of certifier 29c. License number					Nonth, Day, Year)
	-	O.C.M.E.			May 2	29, 2007	
		of acceptable completed course of death (flow 22c)			<u> </u>		
CALIU		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	201				
		7 that 100 lb mile.					
St: Regist	ate rai	31. Date filed (Month, Davidar) Signal 32. Registrar's Signal 32. Registrar 32. Reg					

1. Decedent's Name (First, Middle, Last)

Jack Bryan Pickett

4a. Facility Name (If not institution, give street and number)

burial-trar Division or Vital Records, P.O. Box 68760, funeral director, this

Carroll Westminster Dove House 6. Sex 7. Age (In vrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1 □ MM 2 □ F Nov 25, 1955 Pennsylvania 215-58-3219 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 USA 17 A Washington Lane by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 See 2 No 1979
If Yes, Give
Year or Dates: 2001 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify. White 3 Widowed 4 Divorced 2001 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Army 2^{College (1-4or 5+)} Elementary/Secondary (0-12) Pilot permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irene Taylor Philip G. Pickett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Westminster, MD 21157 1901 Don Avenue Dennis Pickett - Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 6/4/07 Winfield, Maryland 4 Donation 5 Other (Specify) South Carroll Crematory 22. Name and Address of FacilityPritts Funeral Home & Chapel, PA 21. Signature of Funeral Service Licenses 412 Washington Rd. Westminster, MD 21157 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner poalbumi Due to (or as a consequence of): certificate has been signed by the attending physician rector, page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1□ Yes 2 LING 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Dether (Specify) HOS pice 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attendential 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 15tNA Mal calm chive, Went minites 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) erneus 32. Refistrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2007 DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City, Town, or Location of Death

Reg. No.

2007

4c. County of Death

3. Time of Death

5:00 pmM

2. Date of Death

Month 30,

May

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month May 20ď7 31, 8:59A. M **Physician** George C. Schramm, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Laurel Regional Hospital Laurel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 27, 1922 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** New York, N.Y. ¥ M 2 □ F 85 098-14-4938 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2¶ No Springtown Pennsylvania Bucks **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 18081 3155 Church Street 12. Was Decedent Ever in U.S. Armed Forces? 1 (2)Ves 2 □ No If Yes, Give 1943–1945 Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 XNo Specify: Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Federal Government Etementary/Secondary (0-12) Aircraft Metal Worker 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances K. Senior George C. Schramm, 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12809 Innisbrook Drive Beltsville, Maryland 20705 Joan-Marie Stranges -daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 6/1/2007 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death presmon Immediate Cause (Final Physician Due to (or as a consequence of): disease or condition resulting in death) /Medical sprated Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): and sate has been signed by the attending physician page 2 should be detached for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 26. Place of Death (Check only one) completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ဥ 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day Year) Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7350 Van Dusen Road, #320 Laurel, Maryland Marie Dobyns, M.D. 32 egistrar's Signature 31. Date filed (Month, Day, Year) State JUN 04 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year 820 AM 01 0 4a. Facility Name (If Not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Wiconico Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Days 1 M M 2 □ F 75 New Jersey 10/17/1931 138-24-0737 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Maryland Delmar Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21875 30565 Danwood Drive 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ∏Yes 2 □ No If Yes, Give Year or Date**Air Force** 1 Never Married 2 Married 1 ☐ Yes 2 📉 No white Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Government National Security Agency 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Serecko Stephen H. Plaskon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30565 Danwood Dr., Delmar, MD Deloris Plaskon/wife 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Eastern Shore Maryland 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Veterans Cemetery 6/4/07 Hurlock, MD

Physician Medical Examiner

partment of Health al sortant: If Item 27 Is / Injury or other trau

Pages 1 permit. Pages
Department of I
Important: If Ite
any Injury or of

Physician

/Medical

Examiner

Directo

Funeral

by

Completed

Be

Funeral

Director

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

the attending physician been signed by After this certificate has within 24 hours after death To the Funeral Director:

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

	Exar
	<u>@</u>
2	1:8
g	1 2
200	2
5	1.60
D D	.00
Jelac	by Physician/Medical
90	2
e z siloulo de detacrieo loi ose as tre dunai-lia	eted
, page 2	Be Completed
	Be
5	12
u ii) by the lurieral directo	fication:
9	in
Ś	
=	1 2
Ď	0

	21- Signature of Functor Studies Licens	moon CFSP	²² HoT1 501	oway Funeral Snow Hill Rd.	Home Pro	ofessional oury, MD 21	Association 804
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.	•			rest,	Approximate Interval Between Onset and Death
	disease or condition resulting in death)	Due to (or as a consequence of):	DESEA	E		
Juner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. ALZHEIM Due to (or as a consequence of	1RR	DESE	ASE		
al Exan	that initiated events resulting in death) Last	Due to (or as a consequence of					
completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1□ Yes 2□ No 9□ Unknown	23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	pregnancy specify)		elivery Day Year		
d by Pr	Part II. Other significant conditions co	ontributing to death but not resulting in t	the underlying	cause given in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
ompiere					24a. Was autop perfo 1 Yes		utopsy findings available completion of cause of
De (25. Was case referred to medical			26. Place of De	ath (Check only o	ne)	
	examiner? 1 Yes 2 No	Hospital: 1 Nnpatient 2 ☐ ER/Outp	oatient 3 □ D	OOA Other: 4 Nursing I	Home 5 ☐ Resid	dence 6 □Other (Spe	ecify)
110111	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury 28b. Ti	me of ury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe h	now injury occurred	
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm building, etc. (Specify)	n, street, facto	ory, office	28f. Location (S City or Tox	Street and Number or F vn, State)	lural Route Number,
Medical Cerification: 10	29a. Certifier (Check only one) 1 X rtifying Phy	vsician: To the best of my knowledge, iner: On the basis of examination and and manner stated.	death occurre /or investigation	d at the time, date and placen, in my opinion, death occ	e, and due to the curred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
ME	29b. Signature and title of certifier	7	2	9c. License number		29d. Date signed (Mon	th, Day, Year)
	1	1 12	~	DO05841	6	6/1/0	7

Registrar

pletely

RBOX # 1733 SALISBUAY WORKED

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

COASTAL

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month May 28^{bay} 2007 PERRY 15:07 Ε. JAMES 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sep 9, 1935 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 1 XM 2 ☐ F West Virginia Sep 71 235-50-0742 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 1X Yes 2 No Washington 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20002 USA 1922 Bennett P1 N.E. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. rmed Forces.

NYes 2□No1954f Yes, Give 1956 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced **Black**

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

4217 9th St. N.W.

Security Officer

1922 Bennett PL NE

3 Ectopic pregnancy

5 ☐ Other (specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ouantico National

23a. Paper. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Endocarditis

23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Stroke, Pneumonia dysphagia, sacral decub ulcer,

9 Unknown

4☐Pregnant at time of death

16b. Kind of Business/Industry

20c. Location - City or Town, State

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Month

23e. Did tobacco use contribute to the cause of death?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Approximate Interval Between Onset and Death 1 month

Triangle, VA.

Washington, DC 20011

18. Mother's Name (First, Middle, Maiden Surname)

Washington, DC 20002

Lenora Perry

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6-5-2007

Marshall s Funeral Home, Inc.

Chase Bank New York

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

ပ္

10a State

DC

15. Decedent's Education (Specify only highest grade completed)

Tracy Yates-Holman/Daughter

1

Burial 2 □ Cremation 3 □ Removal from State

College (1-4or 5+)

2yrs

Sepsis

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licenses

Alfred Perry

20a. Method of Disposition

Immediate Cause (Final disease or condition

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

disease or condition resulting in death)

IF FEMALE:

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Medical Events.

Examiner burial-tra Physician/Medical as the detached for use ð

equires that the death certificate be executed and physician en signed by t ould be detach

ords, P.O. Box 68760,

Z Z	Physician: The law ruthis certificate has be rail director, page 2 sh	Complet	atrial flutter, I	schemic Cardiomyopathy		24a. Was an autopsy performed?				
Ţ,	in: T ifficat or, pë		25. Was case referred to medical		26. Place of Death	1 Yes 2 No 1 Yes 2 No				
_	Physician: this certific al director,	To Be	examiner? 1 Tes 2 No	Hospital: 1 ★ npatient 2 ER/Outpatient 3	Other	Home 5 ☐ Residence 6 ☐ Other (Specify)				
DIVISION O	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		27. Manner of Death 1X Natural 5 ☐ Pending 2 ☐ Accident investigation		Work?	3d. Describe how injury occurred				
		Certification:	3 ☐ Suicide 6 ☐ Could not be determined		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specity)					
		Medical C		hysician: To the best of my knowledge, death occ miner: On the basis of examination and/or investi- and manner stated.		nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)				
	orthir orthir omp	Me	29b. Signature and life of sertifier		29c. License number	29d. Date signed (Month, Day, Year)				
	F S F O		The max)	D0060117	5/28/2007				
-	rn(2)		30. Name and address of person who	completed cause of death (Item 23a) (Type, Print						
- 1	100		Eric J. Park, M.I). 9901 Medical center	Dr. NE Rockvil	le, MD. 20850				
	Sta Reģist		31. Date filed (Month, Day, Year) JUN 0 5 2007	Same D. Special D.						
DH	MH 17 Rev 1/2	001		,						
				ORIGIN	JAL					

			For State Registrar	State of Maryland			nt of Health an <i>te of Death</i>	d Mental	Hygien		19505
	1000		Decedent's Name (First, Middle, Last)				2. Date			3. Time of Death
4	Physici		Elizabeth Jean	Queen				June		2007	5:00pm M
70	/Medic Examin	S4 -40	4a. Facility Name (If not institution, give	•		4b. City	, Town, or Location of C			. County of Death	
1.	Examili	ei .	Knollwood Manor N			Μi	llersville		A	nne Arur	ide1
	Funeral		5. Social Security Number 6. Se		ast birthday)	If Und	er 1 Year If Under 24	Hrs. 8. Date	of Birth	9. Birth	place (State or Foreign
	Director		215-38-6847	M 200 F 68	Yrs.	Months	Days Hours	Min. (Mont 8/22	h, Day, Year /1938		intry)
30.	D		Usuel Residence of Decedent								
	how		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	a-f s	cto	Maryland Anne Arun	del Sev	ern						1 ☑ Yes 2 ☐ No
	or 28	Directo	10e. Street and Number			10f. Z	ip Code		10g. C	tizen of What Cou	intry?
	23a	a	8011 Fair Breeze D	rive			21144		U	SA	
	dea	Funerai	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Dec	edent of Hispanic Origin ecify Cuban, Mexican, P	? (Specify Yes	or No-	 Race - Amer Black, White 	
9	or it	F	1 ☐ Never Married 2 🔀 Married	1 ☐ Yes 2 No			2X No Specify:				nite
8	ural',	d by	3 Widowed 4 Divorced	Year or Dates:							
ς.	72 h	Completed	15. Decedent's Edu (Specify only highest grad		(Give	kind of w	ual Occupation rock done during most of	f working	16b. ł	Kind of Business/I	ndustry
2	han o	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	IIT o .		use retired) lemaker		1	Private	
2	led v tygie her t		11 17. Father's Name (First, Middle, Last)			поп		Name (First, M	liddle Maide		
Maryland 21215-0036	buid be filed within 72 hours after death with the Maryland Mental Hyglene. arked other than "natural", or iteme 23a or 28a-f show afte event, it a Medical Examinar must be multiled at	Be	Robert Newman					Lizabeth		, comano,	
$\frac{8}{5}$	Mer Mer nark	10		G-/N	405 14-10					or Town State 7	in Code)
<u>a</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or iteme 23a or 28a-f show amy injury or other treumatic event, the Mudical Examination and be notified at ance.		19a. Informant's Name/Relationship (T)			•	ss (Street and Number of				
a)	t and tealth	1	William Queen/Hust		lace of Dispo		Breeze Dri	Date		MD 2114	
Baltimore,	ges it of h		1 Burial 2 ☐ Cremation 3 ☐ F	Removal from State	emetery, crei	natory or	other place)				
Ë	tant:		4 □Donation 5 □Other (Specify,	- 4			Cemetery 6			ntwood,	
<u>a</u>	ermit bepar mpor ny in		21. Signature of Funeral Service Licens				and Address of Facility				
	20540		23a. Part1. Enter the disease, or comp	rucc			ladensburg			oa, MD	20722 Approximate
Part Land	Physician /Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a Oue to (or as a consequence of the conseq	CAST						Interval Between Onset and Death
	uted %	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	uence of):						
Ć	cate be executed physicien and the burial-transit	Exa	resulting in death) Last	Due to (or as a consequ	uence of):						
8760,	ysicie	dical	(d							
9	iffica g ph as th	0	100								
Вох	h cer endin	N/S	230. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Tectonic	pregnancy			23d. Date of deli	
 	deat	icia	in the past 12 months?	4☐Pregnant at time of de 9☐Unknown		Other (Month	Day Year
Ö.	by th	hys	9 Dunknown	9L1 Onknown							
Division of Vital Records, P.O.	quires that the death certifi n signed by the ettending I uld be detached for use as	ed by Physician/M	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	ndertying	cause given in Part I.	230.			the cause of death? bbably 4 Dunknown
8	tw requires been si should I	Completed						24a.	. Was an	24b. Were au	topsy findings available
Re	he la e hes age 2	E C						_	autopsy performed?	death?	ompletion of cause of
ta	vicien: The lav cervilicate hes rector, page 2	0	25. Was case referred to medical				26 Place of	f Death (Check		0 10 163	20110
>	s cert firect	To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 🗆 I	Othor			6 ☐Other (Spec	city)
ō	arthii eral c		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		28c. Injury at Work?		cribe how inj		
0	th. Aft.	tio	1 Natural 5 Pending 2 Accident investigation	(Monin, Day Fear)	Injury	М	1 Yes 2 No				
Divis	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funerel Director: After this certificate hes been signed by the ettending to the Funerel Director: After this certificate as been signed by the ettending to completely illed in by the funeral director, page 2 should be detached for use as	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, st	reet, facto	pry, office		ition (Street a or Town, Sta		ral Route Number,
	Mospit. 24 hours Funere etely fille	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	vsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurre vestigati	ed at the time, date and pon, in my opinion, death	place, and due to occurred at the	to the cause(time, date a	s) and manner as nd place, and due	stated. to the cause(s)
	within 3	₹	29b. Signature and the of certifier	1		2	9c. License number		29d. D	ate signed (Monti	n, Dey, Year)
	->-0		1/2: /	wallace	(un)		D31131	6	IT	UNE 4	7 007
7	(0)		30. Name and address of person who d	ompleted cause of death (Item	23a) (Tvne	Print)			7		,
_	(2/		BRIAN C. U	ompleted cause of death (Iten ALLACE W 32. Registrar's Single	N) (100	5 KILBA	21114	RD, B	HITIMOR	1= mis 21236
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa	Hure						-

		1	For State Registrar	State of	Marylan		artment o			lental Hy	gien Reg. N	000		1000
8		_	Decedent's Name (First, Middle, L.)	.ast)	416-4					2. Date of De	eath		V	3. Time of Death
Physi /Med			Walter Rogers							June 3		007	Year 	10:35 pм
Exam	nine		4a. Facility Name (If not institution, g Clinton Nursing		per)		4b. City, Tow	n, or Location On	of Death			c. County o		rges
Funera Directo	_	,	5. Social Security Number 579 28 8740	Sex 7 1₩ M 2□F	. Age (In yrs. i	ast birthday) Yrs.	If Under 1 Ye Months Da		24 Hrs. Min.	8. Date of Bi	1925	ž) M	9. Birthp Coun lash	lace (State or Foreign try) Lngton, DC
w w			Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation						1	0d. Inside City Limits
Maryle f sho				Georges	C	inton								1 Yes 2 No
with the la or 28a-		runeral Director	10e. Street and Number 9211 Stuart Lane				10f. Zip Coo 2073				_	g. Citizen of What Country? nited States		
death ms 2:		2	11. Marital Status	12. Was Deced		S. 13.	Was Decedent If Yes, specify (of Hispanic Or	ngin? (Sp	ecify Yes or No	D-	14. Race		
partition of the property of the property of the property. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Inmportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	3	2	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Ford 1 JYes 2 If Yes, Give Year or Date	! □ No		If Yes, specify 0			Hican, etc.)		Specify:	, White, Blac	
72 ho	3		15. Decedent's (Specify only highest of	Education grade completed)		(Give	dent's Usual Od	ne durina mo:	st of work	ina	16b.	Kind of Bus	iness/Ind	dustry
vithin vithin han "		nataidilloo	Elementary/Secondary (0-12)	College (1-4	for 5+)	life.	DO NOT use re countan	tired)			GSA	ΛΊ.S.	Goz	rernment
illed v Hygie ther t			17. Father's Name (First, Middle, La	st)		110.	countan		er's Nam	e (First, Middle	<u> </u>			
Id be ental ked o	å	2	Walter E. Rogers					Jei	nnie	e Carey				
shou and M s mar umat		1	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Str				ber, City	or Town, S	tate, Zip	Code)
and 2 aud 2 aulth a n 27 is			J							Ft. Washington, MD 20744				
For the or oth			20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3	☐Removal from St	tate 20b. P	lace of Dispo emetery, cre	osition (Name o matory or other	4		Date	20c. I	Location - C	City or To	wn, State
t. Partmen		-	4 □ Donation 5 □ Other (Spe	1 / / / /	Mai		Nation			9/2007				ryland
Depariment of the position of	ouce.		21. Signature of Funeral Service Lie	ensee! ////)15 12tl						erai 200	Home, LLC
			23a. Part1. Enter to disease r co	prefications that car	used the deat							, 20		Approximate Interval Between
Physicia	n	ŀ	shock, or hart failure. Ist or Immediate Cause (Final disease or condition	ly one cause on eac Cong		Heart	Failur	e						Onset and Death
/Medica	al :		resulting in death)	d	r as a conseq								-	
Examine	-		Sequentially list conditions,	D	nic Rer		ilure							
ted nsit			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	8	rasaconseq rtensio									
execu n and ial-tra		Examine	that initiated events resulting in death) Last	C	r as a conseq									
cate be executed onlysician and the burial-transit		28		d. Non	Insuli	Depe	ndent D	iabetes	5					
entifica ding pl			IF FEMALE:	On If you output	ama of progns	unov.								
death certific attending p		rnysician/inet	23b. Was decedent pregnant in the past 12 months?		th 2 □ Feta nt at time of d	Ideath 3	☐Ectopic pregn ☐ Other (specif					23d. Date Mon		ery Day Year
the d) S	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknov										
w requires that the doben signed by the should be detached		y	Part II. Other significant condition	s contributing to dea	ath but not res	ulting in the u	nderlying cause	given in Part	1.	23e. Did	tobacco	use contril	bute to th	ne cause of death?
equire equire en siç ould t			<u>Dementia</u>							1 🗆	Yes	2 □ No :	3 🗌 Prob	ably 4 Unknown
e law r has be je 2 sh		nataldulon	Peripheral Vaso	cular Dis	ease					24a. Was	psy	pr	ior to co	psy findings available mpletion of cause of
icate l											ormed?		eath?	X □ No
slcian certif rector	ć	0	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	patient 2 🗆	EB/Outpation	nt 3 DOA	Othor:		th (Check only		6 D0+	- (0)	
ding Physician: The lang After this certificate ha funeral director, page		2	27. Manner of Death	28a, Date of		28b. Time o		Injury at Work?	iursing Ho	ome 5 Res 28d. Describe				y)
ath. or: Aft		acio	1 ☑ Natural 5 ☐ Pending investigat	ion	, Day rear)	Injury		1 ☐ Yes 2 ☐]No					
tal or Attends after death		Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	ad Zoe. Place C	of injury - At ho g, etc. <i>(Specif</i>	ome, farm, st	reet, factory, of	ice		28f. Location City or To			r or Rura	I Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		Medical		Physician: To the bacaminer: On the bacaminer and manner	sis of examina									
To the COTTREE COTTREE		M	29b. Signature and title of certifier	- Commence			29c. Lie	ense number			29d. E	Date signed	(Month,	Day, Year)
) K. L	and	im	h ,	MD8	172			Jur	ne 4,	2007	7
R(4)			30. Name and address of person w Khosrow Davac					Ave.,	C1iı	nton, M	D 20	0735 S	Suite	e 409

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar		aryland / Depa	artment of F		Re	g. No.	7 19607	
	Physici	an	1. Decedent's Name (First, Middle, Las Ralpha Mae Hel	•	nie			2. Date of Death	3 ^{Day} 200	3. Time of Death 7 1:30 P M	
	/Medio		4a. Facility Name (If not institution, give			4b. City. Town, o	r Location of Deat		4c. County of Death		
1	Exami	iei	5714 Kenfield Land				Marlboro		P.G.		
	Funeral Director		110 00 07.0	ex 7. Ag □M 2□F	e (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, 02/14/19	8. Date of Birth 9. Birthplace (Month Day, Year) 02/14/1938 Ok.Lahor		
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits	
	Mary a-1 sh	tor	MD PG		Upper Ma	rlboro				Yes 2□No	
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh		
	s 23a	rall	5714 Kenfield Land			207			U.S.A		
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene marked othar than "natural", or Itams 23s or 28s-1 show matic event, the Medical Examinational Le notilled at	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2√2 If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2☐ No	Specify:	pecify Yes or No- to Rican, etc.)	Black,	American Indian, White, etc.	
5-0036	2 hours	ted t	15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occup	pation	1	6b. Kind of Busi		
2	e * 8	nple	(Specify only highest gra	de completed) College (1-4or :	life	kind of work done DO NOT use retired	during most of wo d)				
2	filed withi Hygiene. othar than		17 Februar Nome /First Middle Leet	MS	Т	eacher	10 14-15-4-11-		1000	Public School	
Maryland	s 1 and 2 should be filed within f Health and Mental Hygiene. Itam 27 is marked othar than other traumatic event, Ite M	To Be	17. Father's Name (First, Middle, Last) Ralph Tatum				Ana Ma	ne (First, Middle, Mae Wilson			
Mar	d 2 sho		19a. Informant's Name/Relationship (Rosalinda Renee!	Type, Print) Daug				ural Route Number,			
	Health tam 27 other tr		20a. Method of Disposition	NOWSOIT -	20b. Place of Dispo cemetery, crei			per Marl) 20772 ity or Town, State	
mo	Pages nent of int: if it iry or o		1 ☐ Burial 25☐Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specif		Riverdal			06/2007 E	Riverdal	e, Maryland	
Baltimore,	permit. Pages 1 an Department of Hear Important: if itam 2 any injury or other once.										
8760,	Certificate be executed with the purishment and confidence as the burial-transit	ledicai Examiner	23a. Part. Deter the disease, or one shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c.		er the mode of dyin			ist,	Approximate Interval Between Onset and Death Onset and Death	
.O. Box 6	death certific e attending p ed for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♥ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	Ectopic pregnanc	у		23d. Date Monti		
ds, P	og Deg	by	Part II. Other significant conditions of	ontributing to death b	out not resulting in the u	nderlying cause gru	ven in Part I.			ute to the cause of death?	
Il Records,	The law ate has b page 2 sh	Completed						24a. Was ar autopsy perform 1 Yes 2	pri ned? de	ere autopsy findings available or to completion of cause of ath? Yes 2 \[\] No	
Vital	Physician: The this certificate ral director, page	Be	25. Was case referred to medical examiner?	Hospital:		Ott		ath (Check only one			
28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?									nce 6 □Other w injury occurred		
Division	or the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	286. Place of in	jury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (Str. City or Town.		or Rural Route Number,	
	e Hospital 24 hours a e Funaral (letely filled	edical C	29a. Certifier 1	ysician: To the best niner: On the basis of and manner st	of my knowledge, deat of examination and/or in ated.	h occurred at the til vestigation, in my o	me, date and place opinion, death occi	e, and due to the ca urred at the time, da	use(s) and mani ite and place, an	ner as stated. d due to the cause(s)	
	To the To the campl	Me	29b. Signature and title of certifier			29c. Licens		29	d. Date signed ((Month, Day, Year)	
-) Willa			D SO	686		June 05	, 2007	
R	(10)		30. Name and address of person who Dr. Gurdeep S. Ch	habra, MD	; 14300 Ga	,	Lane, B	owie, MD	20715;	Suite 123	
	Sta Registi		31. Date filed (Month, Day, Year) JUN 0 5 2007	32. Registe	rar's Signawre						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2007 **Physician** AM June 1, 12:45 Sarah Ellen Rogers /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** La Plata Charles Charles County Nursing & Rehab Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🕱 F March 17, 1933 WASHINGTON DC 579-48-4863 74 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Director WALDORF MARYLAND CHARLES 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3893 PINE CONE CIRCLE 20602 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 No Specify. ģ WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 BOOKBINDER U.S. GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROBERT LOUIS ROGERS ANNIE LAURA LAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ANNMARIE RYE - DAUGHTER 7450 SERENITY DRIVE, HUGHESVILLE, MD 20637 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Nurial 2 □ Cremation 3 □ Removal from State JUNE 8. 4 ☐ Donation 5 ☐ Other (Specify) FT. LINCOLN CEM. BRENTWOOD, MARYLAND 22. Name and Address of Facility 3035 01d Washington Rd. 21, Signature of Funeral Service Licenses M00053 ark M Huntt Funeral Home Waldorf, MD 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory 1 months **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Restrictive Years Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ , malnutrition osteu purus 15 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No n 24 hours after death. he Funeral Director: A pletely filled in by the fi death. 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

To the Hos within 24 ho To the Functional

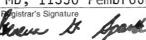
MP 10 State Registrar (Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravinder K. Sindhwani, MD, 11350 Pembrooke Sq., Waldorf, MD 20602 31. Date filed (Month, Day, Year)

R. Sindhward

2007 JUN 0 4



29c. License number

D0061616

29d. Date signed (Month, Day, Year)

611/2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		_	1 -	State of Maryland / Department of Health and M Certificate of Death		giene Reg. No.	07 19609
			1 0	Registrer Jecedent's Name (First, Middle, Last)	2. Date of De	ath	3. Time of Death
	Physicia			Laura Virginia Ridinger	Month	Day	°eer 07 4:25A м
	/Medic			the City. Town and positive of Double	6	4c. County	0,
4	Examin	er		Living		Co	rroll
	Funeral			Country Companion Assisted Taneytown ocial Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Months Min.	8. Date of Bird (Month, Da		9. Birthplace (State or Foreign County) Maryland
	Director			213-01-3163 1 M 2 F 88 Yrs. Months Days Hours Min.		,1918	Märyland
	pu ,			al Residence of Decedent State 10b. County 10c. City, Town or Location		,	10d. Inside City Limits
	aryla shov	-	10a	MD Carroll Taneytown			1 Tes 2 1 No
	he M	ecto	10-	Street and Number 10f. Zip Code		10g. Citizen of V	What Country?
	a or 2	ä	106				,
	eath	erai	11	Harney Rd. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No		e - American Indian,
'	hours after death with the Maryland tural', or Items 23a or 28a-f show at Experiment must be multified at	Funeral Director		Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Біа	ck, White, etc.
8	al', o	þ		If Yes, Give 1 ☐ Yes 2 ✓ No Specify: 3 ✓ Widowed 4 ☐ Divorced Year or Dates:		Specif	White
21215-0036	72 ho	Completed		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of works) iille. DO NOT use retired)	ing	16b. Kind of B	usiness/Industry
2	within ene. then "	idu	E	Elementary/Secondary (0-12) College (1-4or 5+) Seamstress		Sewir	ng Factory
	be filed within 72 hours after death with the Marylan tal Hygiene. Id other then "natural", or Items 23a or 28a-f show event, the Medical Examinat must be mittled at		17	Father's Name (First, Middle, Last) 18. Mother's Name	First, Middle		
anc		Be		Tattle 3 tatile (r wat, tandar)	ie War		
Maryland	2 2 2 2	ပ		a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura			State, Zip Code)
₹	nd 2 sho lith and 27 Is m			Dishard II Didingon Con	2000 T		ster,MD 21158
ē	f Heali f Heali item 2 other		208	a. Method of Disposition 20b. Place of Disposition (Name of Disposition (Name of Disposition compatery compatery or other place)	Date G .		- City or Town, State
30	Pages nent of int: If its			1 ØBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mt. ViewCemetery 6/2		Harr	ney ,MD
Baltimor	artin orte inju		21	. Signature of Funeral Service Licensee 22. Name and Address of Facility		100	17340
ä	Dep Imp			Ruhard Little's FH 34			ttlestown, PA
			23	ia. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory a	ırrest,	Approximate Interval Between Onset and Death
	Physician	gc - 1		1 1			/ Mo
1	/Medical		re	properties to condition sulting in death) Due to (or an consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	.0	3	
	Examiner		Se	opuentially list conditions, b. arterio Schrotic Vascula	nder	lace	2542
	sit s	Examine	if a	duentially list conditions, any, leading to immediate use. Enter Underlying use (Disease or injury) b. Due to (or as a consequence of): Car Mult Torontomic Constitution of the constitu			111-
	and I-tran	хаг	tna	at initiated events sulting in death) Last Due to (or as a consequence of):	7		1.7
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit				,		
687	ficate phys s the	Physician/Medical		d			
ox (aath certifica attending pt for use as t	/W		FEMALE: 23c. If yes, outcome of pregnancy b. Was decedent pregnant 10 to birth 3 Destal death 3 Dectario pregnancy			ate of delivery
ă	death a atte	icial		in the past 12 months? 4 Pregnant at time of death 5 Other (specify)		М	onth Day Year
O.	that the d ed by the detached	hys		9 ☐ Unknown			
٦,	res tha igned I be det	by P	Pa	rt II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.			ntribute to the cause of death?
ğ	w require been sig should b		_		10	Yes 2 100	3 Probably 4 Unknown
Records,	e law re has be ge 2 sho	Completed			24a. Was	psy	Were autopsy findings available prior to completion of cause of
	The late his	E			perf 1 ☐ Yes	ormed? 2 100	death? 1 ☐ Yes 2 ☐ No
Vital	ysicien: The is certificate hadirector, page	Be (25	. Was case referred to medical examiner? 26. Place of Deat	th (Check only	one)	assisted
of \	Physicien: this certific ral director,	မ		1 Yes 2 No No Nursing Ho		how injury occu	her (Specify)
n O	ding Ph. h. After thi luneral	on	27	. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 28b. Time of 28c. Injury at Work? Work? M 1 ☐ Yes 2 ☐ No	200. Describe	now injury occu	Facility
Sio	Attending r death.	cat		2 Accident A	28f. Location	(Street and Num	ber or Rural Route Number,
Division	or At after of Direction by	Certification;		4 Homicide determined building, etc. (Specify)	City or To	own, State)	
	Hospital 24 hours a Funerel I tely filled		2	9a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place,	, and due to the	e cause(s) and n	nanner as stated.
	To the Hospital or Attent within 24 hours after death To the Eunerel Director: completely filled in by the	Medical		(Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	rred at the time	, date and place	, and due to the cause(s)
	To the Within 2 To the comple	Me	29	6b. Signature and title of certifier 29c. License number		29d. Date sign	ed (Month, Day, Year)
	WJL			I Golm Middleton MI 1025443		6/41	12007
	5		30	Name and address of person who completed cause of death (Item 23a) (Type, Print)		,	
_			\	D. Name and address of person who completed cause of death (Item 23a) (Type, Print) John W. Middleton 688 Poole Rd, W.	from in	ster 8	4 Dally
		ate	3	1. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Regist	rar		JUN 0 4 2007 Glow & Cook			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** May 30. 2007 6:55 P Duglio Renato Ricci /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12919 Creamery Hill Drive Montgomery Germantown, 5. Social Security Number if Under 1 Year if Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F Director 40 Sept. 24, 1966 Guatemala 212-21-3055 Usual Residence of Decedent 10c. City, Town or Location 10d. inside City Limits 10a. State 10b. County 1 □Yes 217 No Directo Germantown Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12919 Creamery Hill Drive Funeral 20874 United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1₺Yes 2□No Specify: Guatemalan Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Gasoline 12 Vice President 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Duglio Tentore Ricci ဥ Elida Manchame 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12919 Creamery Hill Drive, Germantown, MD 20874 Maria Paula Robledo (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: if ite
any injury or ot 1 ☐ Burial 2 【ICCREMATION 3 ☐ Removal from State Metropolitan Crematory 6/2/07 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Devol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 21. Signature of Funeral Service Licensee Gaithersburg, 236. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Asphyxia **Physician** disease or condition resulting in death) /Medical s a consequence of) Examiner Sequentially list conditions, it or you have been underlying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 □ Yes 2 □ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1X Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury Certification: self inflicted hanging 5 Pending investigation 1 🗌 Natural May 30 2007 1 Yes 2 Accident

Division or Vital Records, P.O. Box 68760.

death with the Maryland

sa or 28a-f show t be notified at

ms 23a

'natural", or iten dical Examiner

d other than "natur

Pages 1 and 2 should be filed within 72 hours after intent of Health and Mental Hygiene. and the firen 27 is marked other than "natural", or flee ury or other traumatic event, the Medical Examine ury or other traumatic event, the Medical Examine.

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed physician and s the burial-transit SS attending for use as certificate has tirector, page 2 s To the Hospital or Attending Physician: this al dir Director:

3 Suicide 4 ☐ Homicide

29a. Certifier

Medical

6 ☐ Could not be

8 cm

determined

within 24 hours aft To the Funeral Di completely filled in 10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2101 Medical Park Drive #304, Silver Spring, MD 20902 Ira N. Brecher, M.D., 31. Date filed (Month, Day, Year) 32. egistrar's Signature State JUN 0 4 2007 Registrar

28AC

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

クロロチマと

28f. Location (Street and Number or Rural Route Number, City or Town, State) 2919, Crewser

Will Rd, Germantown mo 20874

29d. Date signed (Month, Day, Year)

3/

2007

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Ke mo Dine

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 08 Day 2007 Month **Physician** 4:31A M June Richard Albert Rostien /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Caroline Denton Caroline Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Dec 27, 1 9. Birthplece (State or Foreign Country) New Jersey 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1**X**M 2□ F 222-14-3002 81 Director Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rai', or items 23a or 28a-f ahow Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Caroline 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12079 Greensboro Road 21639 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XI Yes 2 □ No If Yes, Give Year or Dates: 1943/46 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or Item any injury or other traumatic event, Ita Medical Expensions." Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2X No Specify: 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Architectural Engineer US Government 0418. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anna Marie Strohmeier Rostien Conrad Carl Rostien ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marsha R. Sharp/ daughter 13094 Kibler Road Greensboro, Maryland 21639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Greensboro Cemetery 06/12/07 4 ☐ Donation 5 ☐ Other (Specify) Greensboro, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleevle and Helfenbein Funeral Home, PA PO Box 160; Greensboro, Maryland 21639 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition reumonea Physician 245 resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, france, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) the attending physician by Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day detached for 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown δ signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. should be 3 Probably 4 Unknown 2 No 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 2 🗌 No 20 No 1 Tes Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 No 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 6 Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ္ 10 DO047534 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 920 Market Street; Denton, MD 21629 Wafik Zaki, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 2 2007 Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Jean Year 2210 06 200 4a. Facility Name of not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MAGIONAL SOLISBURY Vicimico Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Unde Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months 1 ☐ M 2 🗷 F Days Hours Min 223-96-8367 irginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Virginia 1 ☐ Yes 2 No Exmore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23350 U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Residentia Cleaner 12 Self timployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kaymond 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stevens Virginia Beach, Witchgate Ct. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baptist Church June 16, 2007 Franktown, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune at ervic Lie 22. Name and Address of Facility John O. Morvis 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. NGSSawadox, VA. 23413 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 07 Due to (or as a consequence of): IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 ☐ Other (specify) Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed? Yes 20 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural Injury 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ò

or items 23a

"natural"

marked other

<u>≒</u> ŏ permit. Page Department of Important: If any Injury or

be filed within 72 hours

Pages 1 and 2 should be nent of Health and Mental

Maryland

Baltimore.

event, the Medical Examiner must be notified at

Directo

Funeral

Completed by

Be

Examiner Physician/Medical

the burial-transi as use detached

physician the attending n signed by the After this certificate has been si funeral director, page 2 should t

Division or Vital Records, P.O. Box 68760

Medical

ģ Be 2 Certification:

Completed

After this certificate has within 24 hours after death To the Funeral Director:

> State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Villiam

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

6 Could not be determined

D.D. 31. Date filed (Month, Day, Year) egistrar's Signature **JUN 1 8**

Civic Ave.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Salisbury

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

To the Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2007 Stephens /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner University of Maryland Social Security Number 6. Sex Balhmore
If Under 1 Year | If Under 24 Hrs. | MedicalCenter 8. Date of Birth (Month, Day, June 28 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M M 2 □ F 1935 VIRGINIA 228-46-3225 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show iral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No UPPER MARLBORO PRINCE GEORGE'S Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or: U.S.A. 20774 12710 WHITEHOLME DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No ARMY If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married BLACK 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) GOVERNMENT SCHOOL TEACHER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HUNDLEY STEPHENS ALENE LEVI ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12710 WHITEHOLME DRIVE UPPER MARLBORO, MARYLAND 20774 HELEN H. STEPHENS/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD NATIONAL CEMETERY 6/5/2007 LAUREL, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure Immediate Cause (Final **Physician** congestive Heart disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 5 weeks Mitral if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examiner and as the burial-tran Due to (or as a consequence of) ned by the attending physician detached for use as the buria Be Completed by Physician/Medical IF FEMALE . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. in by the funeral director, page 2 should be 1 | Yes 2 No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No Fibrillation 24a. Was an autopsy performed? Yes 2 No 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 1√No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide

or Attending Physician; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. s after death. To the Hospital within 24 hours at To the Funeral C

the Maryland

Baltimore, Maryland 21215-0036

State Registrar

South Greene Street Baitimore MD 21201 32. Registrar's Sign 31. Date filed (Month, Day, Year)
JUN 0 5 2007

29b. Signature and title of certifier

29a. Certifier

Reinfshil, Resident Physician AU4176435517463 May 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🖂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

31

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^{Day} 2007 **Physician** Theodore Noble Smith, Jr. June 3, 6:22 p.M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Prince Georges 9209 Winterset Court Clinton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | March | 277, 1922 Washington, DC 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** ₩-M 2□ F 579 18 1134 85 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location worle Pages 1 and 2 should be filed within 72 hours after deeth with the Marylar nent of Health and Mental Hygiene.
Instit If item 22 Ie marked other then "naturel", or Iteme 23a or 28s-1 ehow with the traumatic event, the Medical Examinational te intilliar and 1 Re Yes 2 □ No Director Washington DC 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20018-3135 2401 Randolph Street, NE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Black White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 Nidowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DC Public Schools Teacher 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be un-avail. Theresa Theodore N. Smith, Jr. ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9209 Winterset Ct., Clinton, MD 20735 Christine S. Jennings/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Riverdale Crematory 06/05/2007 Riverdale, Maryland permit. Page Department of Importent: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature uneral Service Lice 22. Name and Address of Facility John T. Rhines Funeral Home, LLC 3015 12th St., NE Washington, DC Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pheart follows. List only one cause on each line. Approximate Interval Betw Interval Between Onset and Death Immediate a disease of correction Immediate Cause final disease of condition resulting in death) **Physician** Anemia /Medical Due to (or as a consequence of): Examiner Peripheral Vascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires thet the death certificate be executed burial-transit Decubitus Ulcer Due to (or as a consequence of) Box 68760 Physician/Medical Diarrhea IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day ō in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death P.O. detached 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by Deep Venous Thrombosis 1 Yes 2 No 3 Probably 4 Dunknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an Stroke autopsy performed? 1 Yes 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6x Other (Special Residence Hospital: 1 ☐ Inpatient Certification; To 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending n 24 hours and the Funerel Director: Afternally filled in by the fu 1 ☐ Yes 2 ☐ No investigation 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier Medical 11/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. nptetely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the e 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0

CX (5)

State Registrar 31. Date liled (Month, Pay, Year JUN 0 5 2007

nous

Sisom Osia, MD

32. Registrar's Signature

SMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D48158

6192 Oxon Hill Road, Suite 500 Oxon Hill, MD

June 4, 2007

20745

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Alphonza Smith 30 ,2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Doctors Community Hospital Lanham 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 □ F Months Days Hours 12706/1922 84 Washington, DC 579 14 8628 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD College Park Prince Georges 10g. Citizen of What Country? 10e. Street and Number 20740 United States 5811 Seminole Street by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.

Is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ÎÎNo Black Specify. Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 7 t h College (1-4or 5+) Private/Self Employeed Painter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maude Brown Robert Smith L_O 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health ar
Important: if item 27 Is
any injury or other trau 5811 Seminole St., College Park, MD Mary A. Smith Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □Cremation 3 □Removal from State Lincoln Memorial 06/08/2007 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John T. Rhines Funeral Home, LLC 21 Agnatury 1 Funeral Service License 20017 Washington, DC 3015 12th St., NE a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) Cardiovasular /Medical Due to (or as a consequence of) Examiner Ity perter/100 Sequentially list conditions, if an leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Diabeter Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical as the 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No detached for Month 4⊡Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a 29a, Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the within 2

State Registrar 29b. Signature and title of certifier

James E. Pollack

JUN 0 5 2007

31. Date filed (Month, Day, Year)

32. Registrar's Signature

mo

15 main St.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

MUD 30858

Suite 3SI, Laurel mo.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗍 🗎 🦷 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Year 3, 2007 12:40A June Wayne Franklyn Squier 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince Georges Cheverly PG General Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) Min. Months Days Hours Yrs. July 10,1936 70 577-44-9760 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Tyes 2 No Newburg MD Charles 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20664 12750 Squier Landing Place 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Employment Service/ College (1-4or 5+) Elementary/Secondary (0-12) Farming Business owner 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Sallee Moore Hamilton Squier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 325, Newburg, MD bate Date Glenna Squier/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Brinsfield-Echols Crem. 6/4/07 Charlottee Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) unefal Service Licenses ZAREHART-ECHŌLS FUNERAL HOME, P.A. 211 St. Mary's Ave. La Plata, MD 20646 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Drei monia doin Due to (or as a consequence of): Uno Conce Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a onsequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Disease 24a. Was an

Physician /Medical Examiner

signed by the attending physicien and abe detached for use as the burial-transit

peeu

certificate has

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral di

Be

Certification: To

Medical

or Attending Physician:

the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

10a. State

Director

Funeral

þ

Completed

Be

Funeral

Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 2 any njury or other traumatic event, the Medical Example.

Baltimore, Maryland 21215-0036

the Maryland

Examine that initiated events resulting in death) Last Physician/Medical IF FEMALE 9 🗆 Unknown þ Completed

autopsy 29 No 1 ☐ Yes 26. Place of Death | Check only one)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Thipatient 2 ER/Outpatient 3 DOA 27. Manner of Death

28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Natural

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 HOSPITAL

DANIEL 31. Date filed (Month, Day, Year)

ALEXANDER 32. Redistrar's Signature CHEVERLY, MD 20785

State Registrar

Schmitt, Blanche Maryland 21215-0036

	1	For State	State of Maryl		artment of H rtificate of L			giene Reg. No.	17 18617
Maria Lab		RegIstrar Decedent's Name (First, Middle, Last)				2. Date of Dea	from Test of	3. Time of Death
Physicia /Medica	ıl -	Blanche Naomi Sch					June	6,200	7 1415 1
Examine	r	4a. Facility Name (If not institution, give Memorial Hos	street and number)	Faston	4b. City, Town, or Eas-	Location of Death		4c. County of De	bot
Funeral Director		5. Social Security Number 6. Se		yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da)	9. B y, Year) 8 1925 Ma	Birthplace (State or Foreign Country) ryland
	-	Usual Residence of Decedent		. City, Town or Lo	veation				10d. Inside City Limits
show show	ō	10a. State 10b. County	100		oution.				1 X Yes 2 □ No
the M	Director	Maryland Caroline 10e. Street and Number		Ridgely	10f. Zip Code			10g. Citizen of What	Country?
th with		502 Sunset Boulev	ard			660		USA	
	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	1	Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Black, Wi	nerican Indian, hite, etc. Vhite
nin 72 hou n "natura Medical E	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of work	king	16b. Kind of Busines	·
d with giene er than	E	08	College (1. 461 01)	dome	stic work		- (Fire A Adiabetta	resident:	ial
be file	Be B	17. Father's Name (First, Middle, Last)					hroth Bu	, Maiden Surname)	
marke	၉	Ernest Burns 19a. Informant's Name/Relationship (7)	ype. Print)	19b. Maili	ng Address (Street			er, City or Town, State	e, Zip Code)
and 2 s alth ar 27 is er trau		Lisa Walls/ grand						Maryland :	
Pages 1 shent of He not: if item iny or other		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State		osition (Name of ematory or other place Cemetery	June	9 2007	20c. Location - City Ridgely,	
permit. Departmit. Importa any Inju	1	21. Signature of Funeral Service Licen		1 2	2. Name and Addre	ss of Facility d Helfen : Greens	bein Fur boro, Ma	neral Home aryland 21	639 ^{PA}
		23a. Part1. Enter the disease, or comphock, or heart failure. List only	olications that caused the one cause on each line.	death Donalos	tor the made of duir	a cuch as cardias	or recoiratory a	rroet	Approximate Interval Between Onset and Death
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	nsequence of):	heart muctive merle	Pulmon	e land	110010	
* -	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a co	nsequence of):	aci la	- A C \	arg o	713013	
cate be executed physician and the burial-transit	Examiner	Cause (Disease of Injury that initiated events resulting in death) Last	c. Due to (or as a co	nsequence of):	pjerce	VISIUN)	-		
cate be ey	dical		.d b.						
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of Month	delivery Day Year
uires that the signed by	þ	Part II. Other significant conditions of Type 2	ontributing to death but no	ot resulting in the	underlying cause giv	ven in Part I.			te to the cause of death? Probably 4 Unknown
on or vital necords ding Physician: The law requires h. funeral director, page 2 should be	Completed	Hyperter	Sion				perf	opsy prior formed? deat	e autopsy findings available to completion of cause of h? Yes 2 \sum No
VICAL Iclan: Certifica ector, p	Be C	25. Was case referred to medical examiner?			T		ath (Check only		
Or VITA Physician: r this certific ral director,	မှ	1 □ Yes 20 No	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatie	SIII 3 DOM		T	how injury occurred	Specify)
ding P. After funer	tion:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Ye		Wo	rk?]Yes 2∐No	200. 200020	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e Place of injury	- At home, farm, s Specify)	street, factory, office		28f. Location City or To	(Street and Number o own, State)	or Rural Route Number,
e Hospita 24 hours e Funeral etely filled	Medical C	29a. Certifier 12 Certifying Pl (Check only one)	nysician: To the best of miner: On the basis of ex and manner stated	amination and/or	ath occurred at the t investigation, in my	ime, date and plac opinion, death occ	e, and due to the surred at the time	e cause(s) and manne e, date and place, and	er as stated. due to the cause(s)
To th within To th comp	Me	29b. Signature and Mile of certifier	mi MD			3261		29d. Date signed (N	fonth, Day, Year)
		30. Name and address of pe son who	completed cause of death MEMORIAL	HOSPIT	Print) AZ, EAST	ON, MI)		
Sta Registi		31. Date filed (Month, bay, Year) JUN 0 8 200	MEMO RIAZ 32. Registrar's	Signature	and s				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5611 Patterson Road Riverdale, Maryland 20737

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. r 28a-f show notified at permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be none. Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

10a. State

Director

þ

Completed

Be

ပ္

19a. Informant's Name/Relationship (Type. Print) Inez C. Smock -wife

Andres E. Salazar, M.D.

JUN 04

31. Date filed (Month, Day, Year)

Funeral

Director

Physician /Medical **Examiner**

To tha Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

	20a. Method of Disposition 1		20b. Place of Disposition cermetery, cremate Fort Linco.	ory or other place)	Date 6/5/2007		cation - City of	r Town, State Maryland
	21. Signature of Funeral Service Licens	3 mywai	Dổn 12	ild V. Borg Powder Mi	Wärdt Funer 11 Road Bel	al Ho	me, PA le, Mai	cyland 20705
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line Respira	ne death. Do not enter the tory Failur	ne mode of dying, such				Approximate Interval Between Onset and Death 3 hours
er	Sequentially list conditions	b. Sepsis	consequence of):					5 hours
Completed by Physician/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	cal Pneumoni consequence of): ia	.a				48 hours
ysicianime	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pt 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	☐ Fetal death 3 ☐ Ec	topic pregnancy her (specify)			23d. Date of de Month	elivery Day Year
a ny Pri	Part II. Other significant conditions co	ontributing to death but	not resulting in the unde	flying cause given in Pa			se contribute	to the cause of death? Probably 4XJUnknown
naidillo					24a. Wa aut per 1∐ Yes	topsy rformed?	death?	autopsy findings available completion of cause of s 2 X No
2	25. Was case referred to medical examiner?	Hospital:		Othor	ace of Death (Check only			
ations, 10	1 Yes X No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2	Nursing Home 5 Re 28d. Describ			ecify)
Medical Certification: 10	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc.	y - At home, farm, street, (Specify)	factory, office		(Street an own, State		Rural Route Number,
alical			examination and/or inves		and place, and due to the death occurred at the time			
ME	29b. Signature and title of certifier 30. Name and address of person who c	rles	MD	D51051	er er		te signed (Mor	onth, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

To the

9001 Cherry Lane Laurel, Maryland 20708

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar MFND#19bperFH6/4/07, BMW, MbCb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death J_{une}^{Month} 1, 2007 Dorothy M. Steadman 7:46 Ам 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) 64 yrs 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 1 □ M 2X F 532-40-1330 1942 Washington Oct. 6, Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Montgomery Damascus 1 □Yes 2 XNo Maryland 10f. Zip Code 20872 10e. Street and Number 10g, Citizen of What Country? 24604 Farmview Lane United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11 Marital Status 1 ☐ Yes 2 🗷 No f Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Computer Operator Boeing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ella Hansen Ralph Meyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24604 Tarwisw Lane, Damascus, MD 20872 19a. Informant's Name/Relationship (Type. Print) Russell E. Steadman (Husband) 20b. Place of Disposition (Name of permetery, cremetory or other place) June 2, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2007 Alexandria, Virginia Crematory 22. Name and Address of Facility DeVol Funeral Home, tWER. 10 E. Deer Park Drive, Gaithersburg, MD 20877 Approximate Interval Between Onset and Death months

months

Day

29d. Date signed (Month, Day, Year)

June 1, 2007

Year

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

23a or 28a-f show

or items

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once.

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

Director

Funeral

þ

Completed

Be

ပ္

death with the Maryland

physician ar s the burial-ti After t No the mospins after death.

To the Funeral Director; Af

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

Examine Physician/Medical Completed by Be Certification: To Medical

one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Arijit Dasgupta, M.D.

JUN 0 4 2007

21. Signature of Euneral Service Licensee 1RACC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Due to (or as a consequence of):
End Stage Renal Disease Sequentially list conditions, if any, leading to influential cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Obstructive Sleep Apnea 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Morbid Obesity 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 2 √ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1

Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check onl)

State

Registrar

DHMH 17 Rev 1/2001

M.D

. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

99901 Medical Center Drive, Rockville, MD 20850

D64444

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Agnes Janet Schnoor 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death If Under If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Age (In vrs. last birthday, Social Security Number 1 ☐ M 2 💢 F Months Days Hours Min. 218-12-9874 83 Feb 02 1924 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 ☐ Yes 2X No Maryland Caroline Henderson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15229 West Bridge Court 21640 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Comptroller office Elementary/Secondary (0-12) College (1-4or 5+) Secretary State of Maryland: 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jonathan Rawlings Agnes Schwallenberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15225 Oakland Road; Goldsboro, Maryland 21636 Kathie S. Madigan/ daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Cedar Bluff Cemetery June 13 2007 Annapolis, Maryland 22. Name and Address of Facility PO Box 160; Greensboro, Regular and Helfenbein Funeral Home, PA of Funeral Service Licenses MD 21639 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a consequence of Due to (or as a consequence of): Sequentially not conditione, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 1 (

Physician /Medical Examiner

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

Department of H Important: If Ite any Injury or ot once.

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

12

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

burial-tran attending physician for use as the buria ed by the signed by t page 2 certificate hours after death.

-uneral Director: After the ely filled in by the funeral

that initiated events resulting in death) Last	c. Waldens Due to (or as a consec	nuence of): Na) Sejzul	re		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1□Live birth 2□Fet 4□Pregnant at time of a 9□Unknown	al death 3 ⊟Ectopic pregna			23d. Date of delivery Month Day Year
Part II. Other significant conditions of	contributing to death but not res	ulting in the underlying cause	given in Part I.	23e. Did tobacc	co use contribute to the cause of death? 2☑No 3☐ Probably 4 ☐Unknown
 				24a. Was an autopsy performed 1 Yes 2 ☑	
25. Was case referred to medical			26. Place of Dea	ath (Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Impatient 2]ER/Outpatient 3 □ DOA	Other: 4 Nursing F	lome 5 ☐ Residence	e 6 ⊡0ther (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury V	njury at Vork? □ Yes 2 □ No	28d. Describe how i	njury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, factory, officing	ce	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	nysician: To the best of my knominer: On the basis of examinand manner stated.				e(s) and manner as stated. and place, and due to the cause(s)
29h Signature and title of certifier		29c. Lice	ense number	29d	Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) JUN 1 2 2007

29b. Signature and title of certifier

32/Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 24 hours at To the Funeral D completely filled i

75	1 - State Registrar		o tato	i maryian	•	rtment of F tificate of				Reg. No.		7 . 7 = 1	100
	Decedent's Name	(First, Middle, I	Last)						2. Date of De	ath	The No	131	3. Time of Dea
an cal		Frankli	n Kimmel	Stockmo	$2n S_n$				JUne	Day	2	Year 7	0812
er ier	4a. Facility Name (If	not institution, g	give street and nu	ımber)	, 01.	4b. City, Town, o	r Location of	f Death		4c.	County	of Death	
	MEMORIA	1 Hosf	PITAL	AT EA	MOTE	E	EASTO	SN			TAL	BO	
	5. Social Security Nu	umber 6.	. Sex 1√2 M 2 ☐ F	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birl (Month, Da			Count	ace (State or For
	216-09-7		V_ IVI 2 I	89	Yrs.				June 1	3, 19	17 1	Maryl	and
	Usual Residence of 10a. State	10b. County		10c. City	, Town or Loc	ation						10	d. Inside City Lir
ō	Maryland	Can	oline		Dent	$\circ n$							1 ☐ Yes 2 ☐
Director	10e. Street and Num				200	10f. Zip Code				10g. Citiz	zen of W	Vhat Count	ry?
	410 Colo	nial Da	ino			21629			L	Inite	ed S	tates	of Ame
Funeral	11. Marital Status	uue Dic	12. Was Dec	edent Ever in U.	S. 13. W	/as Decedent of H	ispanic Orio	jin? (Spec	ifv Yes or No		14. Race	e - America	ın Indian,
	1 Never Marrie	ed 2 Married	Armed F 1 DYYes If Yes, G	2 No /////	TT	Yes, specify Cuba ☐ Yes 2 2 No	Specify:	, Puerto F	псап, етс.)			k, White, e	itc.
t by	3 ☐Widowed	4 ☐ Divorced	Year or I	Dates:		Lites ZLALINO	Specify.				Specify		asian
etec	(Speci	15. Decedent's	Education grade completed,	,	16a. Deced	ent's Usual Occup ind of work done O NOT use retired	ation during most	of workin	g	16b. Kir	nd of Bu	isiness/Ind	ustry
Completed	Elementary/Secon	ndary (0-12)	College	(1-4or 5+)	_		d) -			CT		10:	0 0
ပိ	17. Father's Name (First Middle La	not)		Doc	k Worken	18 Mother	r'e Name	(First, Middle,				l Compar
Be	,						10. 11100101					,0)	
은	19a. Informant's Na	ster Si			19h Mailine	Address (Street	and Numbe		tha Amb			State Zin	Code)
	Franklin	•			1	New Bri							*
	20a. Method of Disp		210) 2000	20b. F		ition (Name of latory or other place			ate			City or Tov	
		☐Cremation 3 5 ☐ Other (Spe	B □Removal from	i State		latory or other plac L. Faith (1	1111	2007	B = 0+	l ima	n.o. M	aryland
	21. Signature of Fu				22.	Name and Addre	ss of Facility	/		Duei	MIIIO)	ne, 11	wigeanii
	1 Las	1 april	Mho	4_	Mo	ore Fune South S	ral H	ome,	P.A. 2	,	m	0	1 24/2/
	23a. Part1. Enter the	ie disease, or co	omplications that	caused the deat	n. Do not ente	r the mode of dyir	CONCL ng, such as	cardiac or	respiratory a	z <i>nton</i> rrest,	L, 1'1 6	aryva	nd 21620 Approximate Interval Between
	Immediate Cause (I	Final	20										Onset and Death
	resulting in death)	-	Due to	(or as consequent	uence of):	1100		1 4	~U~				
	Sequentially list con	ditions	b A	2740	_ (sev- T	Tail	0 ^	-e_				
iner	if any, leading to im cause. Enter Under Cause (Disease or i	mediate	Due to	(or as a consequ	uence of).		\						
] []	Cause (Disease or i that initiated events		c	orto	<u> </u>	su ato	5:5						
ā	regulting in death) I	ası	Due to	(or as a consequ	uence of):								
I Examiner	resulting in death) L												
-	resulting in death) L	•	d										
-	IF FEMALE:		d	itcome of pregna	incv						22d Dat	to of dolivo	
-	IF FEMALE: 23b. Was decedent in the past 12	months?	1 ☐Live	utcome pf pregna birth 2 □ Feta	Ideath 3□	Ectopic pregnanc	y			2	23d. Dat	e of deliver	ry Day Year
-	IF FEMALE: 23b. Was decedent	months?	1 ☐Live	birth 2□Feta jnant at time of d	Ideath 3□	Ectopic pregnanc Other (specify)	у			2			•
Physician/Medical E	IF FEMALE: 23b. Was decedent in the past 12 1 □ Yes 2 □	months?	1 □Live 4□Preg 9□Unki	birth 2 Feta gnant at time of d nown	I death 3□ eath 5□	Other (specify)			23e. Did t		Мо	nth	•
by Physician/Medical E	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 □Live 4□Preg 9□Unki	birth 2 Feta gnant at time of d nown	I death 3□ eath 5□	Other (specify)				obacco u	Moi ise conti	nth	Day Year
by Physician/Medical E	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 □Live 4□Preg 9□Unki	birth 2 Feta gnant at time of d nown	I death 3□ eath 5□	Other (specify)				obacco u Yes 2[Moisse conti	nth ribute to th 3 Proba	Day Year
by Physician/Medical E	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 □Live 4□Preg 9□Unki	birth 2 Feta gnant at time of d nown	I death 3□ eath 5□	Other (specify)			1 🔲 24a. Was auto perfo	obacco u Yes 2[an psy primed?	Moise contr	nth ribute to th 3 □ Proba Were autoporior to condeath?	Day Year e cause of death ably 4 Whikn by findings avail apletion of cause
Completed by Physician/Medical E	IF FEMALE: 23b. Was decedent in the past 12 1	months?	1 □Live 4□Preg 9□Unki	birth 2 Feta gnant at time of d nown	I death 3□ eath 5□	Other (specify)	en in Part I.	of Death	1 🗍 24a. Was auto perfo 1 🖂 Yes	obacco u Yes 2[an psy primed?	Moise contr	nth ribute to th 3 □ Proba Were autoporior to condeath?	Day Year e cause of death ably 4 Dunkn
Be Completed by Physician/Medical E	IF FEMALE: 23b. Was decedent in the past 12 1	months?	1 Live 4 Preg 9 Unki	birth 2 ☐ Feta nnant at time of d nown death but not resi	l death 3 □ eath 5 □	Other (specify)	26. Place		24a. Was auto perfo	obacco u Yes 2[an psy primed? 2 No	Mo See control No 24b. \	nth ribute to the 3 □ Proba Were autoporior to condeath? I □ Yes	Day Year e cause of death ably 4 Denkn psy findings avail apletion of cause
To Be Completed by Physician/Medical E	IF FEMALE: 23b. Was decedent in the past 12 1	red to medical	1 □ Live 4 □ Prec 9 □ Unki	birth 2 Feta nant at time of d nown death but not resi	eath 5 ulting in the un	Other (specify) derlying cause giv	en in Part I. 26. Place er: 4 Nu	rsing Hom	1 🗍 24a. Was auto perfo 1 🖂 Yes	an property of the control of the co	Moon see control No 24b. No 1	ribute to the 3 Probate Probat	Day Year e cause of death ably 4 Denkn psy findings avail apletion of cause
To Be Completed by Physician/Medical E	IF FEMALE: 23b. Was decedent in the past 12 1	icant conditions	1 Live 4 Prec 9 Unki s contributing to 6	birth 2 ☐ Feta nnant at time of d nown death but not resi	death 3 eath 5 ulting in the un	Other (specify)	en in Part I. 26. Place er: 4 Nu	rsing Hom	24a. Was autoperformer 1 Yes	an property of the control of the co	Moon see control No 24b. No 1	ribute to the 3 Probate Probat	Day Year e cause of death ably 4 Denkn psy findings avail apletion of cause
To Be Completed by Physician/Medical E	IF FEMALE: 23b. Was decedent in the past 12 1	icant conditions	Hospital: 1 Live 4 Preg 9 Unki	birth 2 Feta prant at time of d nown death but not resi lipeatient 2 e of Injury nth, Day Year) se of injury - At he	eath 5 ulting in the un ER/Outpatient 28b. Time of Injury	Other (specify)	26. Place er: 4 □ Nui y at k?	rsing Hom 2 No	24a. Was autoperficulty for the solution of th	obacco u Yes 2[an psy omed? 2 No one) dence (how injur	Moon see control No 24b. \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	nth sribute to th ribute to th ribute to th ribute to th were autoporter to condent	Day Year e cause of death ably 4 Denkn psy findings avail apletion of cause
To Be Completed by Physician/Medical E	IF FEMALE: 23b. Was decedent in the past 12 1	red to medical 5 Pending investigat 6 Could not	Hospital: 1 Live 4 Preg 9 Unki	birth 2 Feta ynant at time of d nown death but not resi lipeatient 2 e of Injury nth, Day Year)	eath 5 ulting in the un ER/Outpatient 28b. Time of Injury	Other (specify)	26. Place er: 4 □ Nui y at k?	rsing Hom 2 No	24a. Was auto perfc 1 Yes (Check only cone 5 Resided. Describe	obacco u Yes 2[an psy omed? 2 No one) dence (how injur	Moon see control No 24b. \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	nth sribute to th ribute to th ribute to th ribute to th were autoporter to condent	Day Year e cause of death ably 4 Whikn asy findings avail appletion of cause
edical Certification: To Be Completed by Physician/Medical F	IF FEMALE: 23b. Was decedent in the past 12 1	red to medical To be considered to medical To could not determine	Hospital: 15 28a. Date (Mo. tion t be ed Delice Physician: To the kaminer: On the	birth 2 Feta grant at time of d nown death but not resi e of Injury nth, Day Year) re of injury - At ho ding, etc. (Specif	ER/Outpatient 28b. Time of Injury wheel, farm, stre	Other (specify)	26. Place 26. Place ier: 4 □ Nu y at k? Yes 2 □ №	rsing Hom 2 No 2 d place, a	24a. Was autoperting the second of the secon	an psy ormed? All No one) dence (how injur Street ann. State cause(s)	Moon see control No 24b. No 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ribute to th 3 Probi Were autoporior to condeath? er (Specify red	Day Year e cause of death ably 4 Donkn osy findings avail npletion of cause 2 Doo Route Number,
To Be Completed by Physician/Medical E	IF FEMALE: 23b. Was decedent in the past 12 1	icant conditions red to medical No 5	Hospital: 15 28a. Date (Mo. tion t be ed Delice Physician: To the kaminer: On the	birth 2 Feta gnant at time of d nown death but not resi death but not resi death but not resi death but not resi death but not resi death but not resi death but not resi	ER/Outpatient 28b. Time of Injury wheel, farm, stre	Other (specify)	26. Place ver: 4 □ Nui y at k? Yes 2 □ N me, date an opinion, dea	rsing Hom 2 No 2 d place, a	24a. Was autoperting the second of the secon	an psy orne) dence (how injur Street anwn, State cause(s) date and	Moon size control No 24b. No 24b. No 156 Other y occurred Numb 15 and mad 15 place,	ribute to th 3 Probi Were autoporior to condeath? er (Specify red	Day Year e cause of death ably 4 Linkn psy findings avail apletion of cause 2 Lito Proute Number, ated. the cause(s)
edical Certification: To Be Completed by Physician/Medical F	IF FEMALE: 23b. Was decedent in the past 12 1	icant conditions red to medical No 5	Hospital: 15 28a. Date (Mo. tion t be ed Delice Physician: To the kaminer: On the	birth 2 Feta gnant at time of d nown death but not resi death but not resi death but not resi death but not resi death but not resi death but not resi death but not resi	ER/Outpatient 28b. Time of Injury wheel, farm, stre	Other (specify)	26. Place 26. Place ier: 4 Nu y at k? Yes 2 N me, date an opinion, dea	rsing Hom 2 No 2 d place, a	24a. Was autoperforment of the service of the servi	an psy orne) dence (how injur Street anwn, State cause(s) date and	Moon see control No 24b. No 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ribute to th 3 Probi Were autoporior to condeath? I Pes er (Specify red anner as stand due to d (Month, L	Day Year e cause of death ably 4 Linkn psy findings avail apletion of cause 2 Lito Proute Number, ated. the cause(s)
edical Certification: To Be Completed by Physician/Medical F	IF FEMALE: 23b. Was decedent in the past 12 1	red to medical No 5 Pending investigat 6 Could not determine title of certifier	Hospital: 1 28a. Date (Mo. tion to be ed bulk) Physician: To the xaminer: On the and ma	birth 2 Feta inant at time of d nown I logatient 2 death but not resi death but not resi death fluiry and fluiry and fluiry - At ha ding, etc. (Specif ne best of my kno basis of examina nner stated.	ER/Outpatient 28b. Time of Injury wledge, death tion and/or inv	Other (specify)	26. Place eer: 4 \(\text{Nu}\) y at k? Yes 2 \(\text{N}\) me, date an opinion, dea	No 2 d place, a	24a. Was autoperformer of the second of the	an psy primed? an psy primed?	Moon see control No 24b. No 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ribute to th 3 Probi Were autoporior to condeath? I Pes er (Specify red anner as stand due to d (Month, L	Day Year e cause of death ably 4 Denkn by findings avail appletion of cause 2 Day Route Number, ated. the cause(s)

Registrar DHMH 17 Rev 1/2001 JUN 1 1/2007

			1 - State of Maryland	•	rtment of H tificate of L		Mental Hy	0	10.	110000
r			Registrar 1. Decedent's Name (First, Middle, Last)	061	incate of L	Jean	2. Date of De	Reg. No.		3. Time of Death
	Physicia /Medic		HATTIE THARPE				JUNE	3 2	Year 007	15:50 ^M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Deat	h	4c. County		
1	ing Ing		HOLY CROSS HOSPITAL		SILVER			MON	TGOM	ERY
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. lass	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, D.	ay, Year)	9. Birth Col	nplace (State or Foreign untry)
Ь	Director		438-24-9615 78 Usual Residence of Decedent	TIS.			May 6,	1929	Geo	rgia
	land ow at		10a. State 10b. County 10c. City, T	own or Loc	ation					10d. Inside City Limits
	Mary I-f sh fied	į	MD Montgomery S:	ilver	Spring					1 ☐ Yes 2 K No
	th the or 28g	irec	10e. Street and Number	LIVOI	10f. Zip Code			10g. Citizen of	What Co	untry?
	th wit	al [1316 Fenwidk Lane #608		209	10		US	A	
	r dea tems er m	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (S In, Mexican, Puer	Specify Yes or Note to Rican, etc.))- 14. Ra	ce - Amer	ican Indian, , etc.
20	s afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No If Yes, Give 3 ☐ Widowed 4 🛣 Divorced Year or Dates:		☐Yes 2. No	Specify:		Specia	5.0	
2-002	hour tural			I6a Deced	ent's Usual Occupa	ation		16b. Kind of B		Lack
<u>.</u>	in 72 n "na Aedic	Completed	(Specify only highest grade completed)	(Give I	kind of work done of NOT use retired	during most of wo	rking	Tob. Killa of E	u5111655/1	ildusity
<u> </u>	y with giene r than	mo	Elementary/Secondary (0-12) College (1-4or 5+) 4yrs.	Socia	al Worker			Priv	ate	
aua,	al Hyg I othe vent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle	, Maiden Surna	ne)	
	Menta Menta arked atic e	ToE	Mose Harris			Rosa Ha	arris			
<u>a</u>	2 sho and is ma		19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street a	and Number or R	urai Route Numb	er, City or Town	, State, Z	ip Code)
E Č	and fealth m 27 her tr		* *		ranklin A	Ave. Si		ing, Md		
	it of F If Ite or ot		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	etery, crem	sition (Name of natory or other plac	,	Date	20c. Location		
Daltimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.				oln Cemet			Brentwo	ood,	MD.
D D	permit Depar Impor any ir		21. Signature of Funeral Service Licensee		Name and Address				2 200	N 1 1
			23a. Part1, where the disease, or complications that caused the death. shock or heart failure. List only one cause on each line.		217 9th S or the mode of dying				5 200	Approximate
	Physician		Immediate Cause (Final							Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Threfstitial a		Disease				-	
	Examiner		Pneumonia							
	70 Æ	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ice of):						
	ecute and -trans	Examiner								
0,00,	icate be executed physician and s the burial-transit	al E	Due to (or as a consequent	ice oi).						
000	ficate phys s the	dical	d							
מא	certifi nding use a	₩	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnance					23d. Da	ate of deli	verv
0	death e atte d for	icia	in the past 12 months? 1 Ves 2 XNo. 1 Pregnant at time of deat		Ectopic pregnancy Other (specify)				onth	Day Year
5	t the by the tache	Physician/Me	9 ☐ Unknown							
ń	The law requires that the death certificate has been signed by the attending is age 2 should be detached for use as	ру Р	Part II. Other significant conditions contributing to death but not resulting	ig in the un	derlying cause give	en in Part I.	23e. Did	tobacco use con	tribute to	the cause of death?
colos,	equir	ted					1 🗆	Yes 2 No	3 □ Pro	bably 4X Unknown
ט	law las be	Completed					24a. Was	an 24b.	Were aut	topsy findings available ompletion of cause of
<u> </u>	: The	S					perf 1□ Yes	ormed?	death? 1 ☐ Yes	2⊠ No
V II	rsician: The law s certificate has b irector, page 2 s	Be	25. Was case referred to medical examiner? 1		3D DOA Othe)r.	ath (Check only			
5	ding Phys	. To	TEATINDATION TEATINDATION 2 LEN	Outpatient Bb. Time of	3 DOA	4 LI Nursing F		idence 6 Oti		ify)
5	th. th. : Afte	tion	1 □Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury	28c. Injury Work	k? Yes 2∐No	200. 2000.20	now injury coour	100	
2	Attending Physician: The Isr death. ector: After this certificate he by the funeral director, page	ifica	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (Street and Numi	ber or Ru	ral Route Number,
5	s afte	Certification:	unding, etc. (Specify)				City or 10	wn, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director, gompletely filled in by the funeral director.		29a. Certifier (Check only (C	dge, death	occurred at the tin	ne, date and plac	e, and due to the	cause(s) and m	anner as	stated.
	the Ihin 24 the F	Medical	one) and manner stated.							
	T wit	2	29b. Signature and title of certifier	D	29c. License			29d. Date signe	·	, vay, Year)
1	(6)		1,00,000	· /	DD635	/9		6-4-20	JU 7	
11	~(2/		30. Name and address of person who completed cause of death (Item 23 Maria Tayag, M.D. 1500 Forest		•	ver Spri	no Ma	20910		
	Sta	te			wa. DII	ver phri	ing, nu.	20910		
	Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Registrar's Signature	B)						

DHMH 17 Rev 1/2001

			1- State of Maryland / Depar	rtment of F			giene Reg. No. 20	117 10523
×	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of De	ath Day Y	3. Time of Death
1	/Media	cal	MAMIE LOUISE LEE THOMPSON 4a. Facility Name (If not institution, give street and number)	4b. City, Town, a	r Location of Death	MAY	30, 20	007 9:33 P M
	LAGIIII		SOUTHERN MARYLAND HOSPITAL CENTER	CLIN	LON			E GEORGES
ì	Funeral Director		5. Social Security Number 216-22-2669 6. Sex 1 M 2 F X F 82 Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da FERUARY	th y, Year) 26, 1925	9. Birthplace (State or Foreign Country) MARYLAND
	w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ation				10d. Inside City Limits
	Maryla Ff sho fied at	tor	MARYLAND CHARLES LA PLATA					1 XYes 2 No
	ith the	Direc	10e. Street and Number	10f. Zip Code			10g. Citizen of Wh	•
	eath w Is 23a must !	Funeral Director	9795 HALF PLACE 11. Marital Status 12. Was Decedent Ever in U.S. 13. W	2064			UNITED ST	ATES American Indian,
36	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show edical Examiner must be notified at	by Fun	1 Never Married 2 Married 1 Yes 2 No.	Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puert Specify:	o Rican, etc.)	Black, Specify:	White, etc. BLACK
2-0036	52 8 5	Completed I	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give ki	ent's Usual Occup	during most of wor.	king	16b. Kind of Busin	
12.12	I withi liene. r than the M	omp	Elementary/Secondary (0-12) College (1-4or 5+)	O NOT use retired SEKEEPIN(,		PRIVATE	3
מ		BeC	17. Father's Name (First, Middle, Last)				Maiden Surname)	
ryland	2 should be and Mental is marked o raumatic eve	2	HOWARD WILMER LEE				BOND LEE	
Z Z	D = 7 = 0						er, City or Town, St MARYLAND	/
more,	ages 1 ant of He		IA Buriai 2 Cremation 3 Removal from State	atory or other plac		Date F. 7. 2007	20c. Location - Ci	
baltll	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other		21. Signature of Funeral Service Movins 1	Name and Addre	ss of Facility FUNERAL H	IOME, P.	Α.	
	402.00	3	23a. Part1. Enter the disease, or complications that caused the death. Do not enter	439 LIVII	NGSTON RO	DAD, IND	<u>LAN HEAD,</u>	Approximate Interval Between
	Physician	l a	shock, or heart fallure. List only one cause on each line. Immediate Cause (Final disease or condition a Advanced Emph	ysema.				Onset and Death Unknown
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, learning to minimulate cause. Enter Underlying Cause (Disease or injury that initiated events at the conditions) of the conditions of the cause (Disease or injury that initiated events are consequence of conditions).	0 1.				Unknows
		Jer	Sequentially list conditions, if any, leading to himboliate cause. Enter Underlying Cause (Disease or injury)	nac ()	Jara			011/2/2027
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (plas a consequence of):	+ Failu	a			Unknown
8/00,	icate be executed physician and s the burial-transit	edical E	d.					
00	ertificat ing phy e as th		IF FEMALE:					
O. DOX	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ E	Ectopic pregnancy Other <i>(specify)</i>	4		23d. Date of Month	•
ν̈́,	ss that t gned by ie detad	by Ph	Part II. Other significant conditions contributing to death but not resulting in the und	derlying cause giv	en in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
ecords,	require een sig					1 🗆 \	/es 2 □ No 3	☐ Probably 4 MUnknown
Jac I	The law ate has b page 2 sl	Completed				24a. Was autop perfo 1□ Yes	prior prior prior dea	ere autopsy findings available or to completion of cause of ath? Yes 2 🛣 No
VICAI	sician: certific rector,	Be	25. Was case referred to medical examiner? Hospital: Hospital:	3 DOA Oth	26. Place of Dea			
5	g Physer this seral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	3 DOA 28c. Injur	4 LI Nursing H		lence 6 Other now injury occurred	
	tendin eath. or: Aft	atio	1 ☑ Natural 5 □ Pending (Month, Ďaý Year) Injury 2 □ Accident investigation 3 □ Suicide 6 □ Could not be	M 1 🗆	Yes 2 □ No			
	tal or Att s after d al Direct ed in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At home, farm, stree building, etc. (Specify)	et, factory, office		28f. Location (S City or Tou		or Rural Route Number,
	ne Hospit 24 hour ne Funera eletely fille	Medical (29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investant and manner stated.	occurred at the tirestigation, in my c	me, date and place opinion, death occu	, and due to the irred at the time,	cause(s) and manr date and place, an	ner as stated. d due to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier Anothe Fahren M. O	29c. License	e number		29d. Date signed (Month, Day, Year)
10			30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	rint)	1 1 1	3-61 (1 - (00)	28 MA 20902
17	NP 4 Sta	te	Rointan FARAH FAR M.O. 9801 G 31. Date filed (Month, Day, Year) 32. Registrar's Signature	eorgia	AVE JUIL	/ ۱۱ ک ۱۱ - ت	ار اد کس	7.020102
	Registr		JUN 0 4 2007 Kleeve & B	conti				

DHMH 17 Rev 1/2001

Amended Item 10e per F.D. 06/01/2007 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30 Month 5 2007 3:35 PM Erika Tubies /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Carroll Taney Low Li

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | Aug. 27, 1 Taneytown 5235 Babylon Rd. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□M 2√F 1939 Director 216-36-4009 67 Germany Usual Residence of Decedent filed within 72 hours efter deeth with the Meryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County a or 28s-f show 1 ☐ Yes 2 ☑ No Carroll Taneytown MD 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 5235 5235 Babylon Rd. **5** USA <u> 21787</u> Babylon 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) cook Youth Home end Mental Hygi 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be d 2 should be fl th end Mental F Theodore W. Lichtenberger Pearl Becker ပ traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5235 Babylon Rd. Taneytown, MD it. Pages 1 and 2 introduct of Health entant: if item 27 in njury or other tra Arthur Tubies, husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 6/2/07 Littlestown, PA njury or 4 □ Donation 81 Other (Specify) Mount Carmel Cemeters 21. Signature of Funeral Service Licens 22. Name and Address of Facility 34 MAple Ave. Littlestown Little's F.H. 23a. Part1. Enter the disease, or complication a shock, or heart failure. List only one cau the de do Do riot enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Attending Physician: The lew requires that the death certificate be executed signed by the ettending physicien end d be deteched for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificete 1 ☐ Yes 2 3 No 1 Yes 2 No : After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification; To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation To the Hospital or Attend within 24 hours effer deeth To the Funerel Director; 2 Accident the th 6 Could not be determined 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 29a. Certifier 1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signati and title of certifie WJL completed cause of death (Item 23a) (Type, Print) 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 1 were & facili 2007 Registrar

			1 - State AMEND#788, perFH	State of Ma ,6/7/07,DPS,			rtment of I dificate of				giene	007	19625
			1. Decedent's Name (First, Middle, Las	st)		_				2. Date of De			3. Time of Death
	Physici		Talan Tana	Towns						Month May	24	Year 2007	7 5:27 A ^M
i	/Medio Examin		John Leon 4a. Facility Name (If not institution, give				4b. City, Town, o	or Location	of Death	пау		ounty of Death	
			14600 Almanac I	rivo			Burto	ne v11	10		Mo	ontgome	2 ~ W
	Funeral		Social Security Number 6. Security Number	ex 7. Ag	e (In yrs. last birt		If Under 1 Year	If Unde	r 24 Hrs.	8. Date of Bin (Month, Da	h Year 10	9. Birth	hplace (State or Foreign
	Director		263-52-5999	⊠ M 2□F	70 68	Yrs.	Months Days	Hours	Min. S	eptember	18, 19	36 F	untry) Lorida
	<u> </u>		Usual Residence of Decedent										
	how	_	10a. State 10b. County		10c. City, Towr	n or Loca	ation						10d. Inside City Limits
	Ba-f	cto	Maryland Montgom	ery		1	Burtonsvil	l1e					1 ☐ Yes 2 🗷 No
	it it	Director	10e. Street and Number				10f. Zip Code				10g. Citizer	n of What Co	untry?
	23a	ia i	14600 Almanac	Drive				20866				U.S.	1117
9	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or Items 23a or 28e-i ehow aumatic event, the Medical Examinar must be mutified at	Funerai	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Armed Forces? 1 ⊠Yes 2 ☐ I If Yes. Give	No	lf '	as Decedent of H Yes, specify Cub	an, Mexic	an, Puerto P	cify Yes or No lican, etc.)		Race - Amer Black, White	
8	ours	l by	3 Widowed 4 Divorced	Year or Dates:]	L976-1982	11	□Yes 2 MINo	<i>эрөсп</i>	y. 		31	pe <i>cify:</i>	B1ack
5-0	72 h	Completed	15. Decedent's Ed (Specify only highest gra		16a.		nt's Usual Occup ind of work done		st of workin	а	16b. Kind	of Business/I	Industry
7	ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. Do	O NOT use retire	d)		9			
7	ygier yer th	ပ္ပ		2		Procu	rement Co						overnment
ם	tal Hy	Be	17. Father's Name (First, Middle, Last)							(First, Middle,			
<u>ya</u>	should I	၉	Harry Towns					1	Annie	Una	scerta	inable	
Maryland 21215-0036	ges 1 and 2 should it of Health and Men it If Item 27 le marke or other traumatic		19a. Informant's Name/Relationship (7	Type, Print)	19b.	Mailing	Address (Street	and Numi	ber or Rural	Route Numbe	er, City or T	own, State, Z	(ip Code)
	ges 1 and 2 it of Health If Item 27 I or other tra		Kim OK Towns	- Wife			Almanac I	rive,			Mary1a	nd 20866	5
ore.	of Herr		20a. Method of Disposition 1 Burial 2 Cremation 3	Domoural from State	20b. Place of cemeter	Disposi y, crema	ition (Name of atory or other pla	ce)	Da	ite	20c. Loca	tion - City or 1	Town, State
Ĕ	Pages nent of I		4 Donation 5 Other (Specify		Ft. Lin	coln	Crematory	,	June 8	, 2007	Brent	wood, Ma	aryland
Baltimore,	permit. Page Department of Importent: If any Injury or once.		21. Signature of Eugetal Service Licen	see .			Name and Addre			no Inc			
m	99 = 9		Similar				nes-Rinald 800 New Ha					ing, Mar	ry1and 20904
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused	the death. Do r								Approximate Interval Between
	Physician		Immediate Cause (Final			D							Onset and Death
1	/Medical		disease or condition resulting in death)	a	nary Arte		Lsease						10 years
	Examiner			· ·	ertension	,							10 years
		Je.	Sequentially list conditions,		a echequanea (И).							10 years
	uted d ansit	Ē	d any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. Di al	etes								10 years
Ċ.	be executed sicien and burial-transit	Examiner	resulting in death) Last		a consequence of	of):							10 Journ
8760,	e be rsicie e bur	dicai		d									
9	ificate g physi as the	edi									- 1		
Вох	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							230	d. Date of deli	very
	death a atte	Cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at	2 Fetal death time of death		Ectopic pregnanc Other <i>(specify)</i> _	у				Month	Day Year
o.	that the de ed by the a detached f	hys	9 Unknown	9□ Unknown									
a .	s thai	by P	Part II. Other significant conditions of	ontributing to death b	ut not resulting in	the und	derlying cause giv	en in Part	1.	23e. Did t	obacco use	contribute to	the cause of death?
Records,	quires n sign uld be	D D								101	res 2 🛣 N	√o 3∏Pro	obably 4 Unknown
00	w require been si should b	Completed								24a. Was	an 2	24b. Were au	topsy findings available
æ	The lav	E								autop	rmed?	death?	topsy findings available completion of cause of
Vital			25. Was case referred to medical					00. 51		1 Yes		1 LJ Yes	2□ No
>		o Be	examiner?	Hospital: 1 ☐ Inpatie	ent 2 ER/Out	lootiont.	20 DOA Ott	200		(Check only o		70shaa (C	4.1
Division of	Physic ruthis aral di	. To	27. Manner of Death	28a. Date of Inju	ry 28b. T	ime of	30 004	4 🗆 1		e 5 🗷 Resid			erry)
0	ding for the standard fundral	ţ	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year) Ir	njury	28c. Inju Wo	rk? ∣Yes 2[□No				
S	or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not be	28e. Place of Ini	ury - At home, fai	rm, stree				Bf. Location (Street and N	√umber or Ru	ral Route Number.
á	i gitte	Certification:	4 Homicide determined	building, ef	c. (Specify)		, , ,			City or Tov	vn, State)		
	To the Hospital or within 24 hours after To the Funeral Director completely filled in		29a Certifier 1X Certifying Ph	ysician: To the best	of my knowledge	death :	conumact at the ti	ma, date a	ind place, a:	id dua to the	панен(е) ал	id is active as	etatad
	n 24 n 24 n Fu	Medicai	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examination and ated.	d/or inve	stigation, in my	opinion, de	eath occurre	d at the time,	date and pla	ace, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier				29c. Licens					signed (Month	, , ,
			> Colambell	m			80	035	363		6	11/07	
1	0		30. Name and widness of person who	completed cause of d	leath (Item 23a) (Туре, Р	rint)						
			Sandra Mars	rallmo P	SVANC	16	N. Gree	ne S	t. R	althou	me 1	1021	1201
7	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	1				1111	-		
	Registr	ar	JUN 0 4 20	107 Best	as St.	600							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** AM 2007 9:20 Bell Leona Turacy June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Charles La Plata Genesis Care LaPlata Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 29, 1 Birthplace (State or Foreign Country)
_ 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1923 Pennsylvania 203-12-1572 84 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary/an Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 1X□Yes 2□No Directo Springfield Virginia Fairfax 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 22152 6134 Bardu Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 1 If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 White <u>ک</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Real Estate Elementary/Secondary (0-12) Broker 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary M. Vargo John Kopsco 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6134 Bardu Avenue, Springfield, VA 22152 Darlene M. Moretti - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) JUNE Date 7. 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Pittsburgh, PA Calvary Cemetery 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3035 Old Washington Road M00053 Huntt Funeral Home Waldorf, MD 20601 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) UTERINE **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physiciar IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown THRIVE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has DIJEADI 1∐ Yes 2_1\\0 Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No To the
within 24 hours after deau..
To the Funeral Director: After this c ဥ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury at Work? Certification: 1 □ Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D444360 s of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

2007

				se Type or Prin	nt in Bl TEM#5 aryland					e All WS nd Me	Copies	s Are /giene	Legib	le.		
			1 - State Registrar			Cei	rtifica	te of	Death			Reg. No.	201	17	100	123
	Physici	an	Decedent's Name (First, Middle,	, Last)						2	. Date of D Month	eath Day	/	'ear	3. Time of	Death
	/Medic			lbert Turkir	rgton						lune	7	200	7	10:38	P^{M}
	Examin	ner	4a. Facility Name (If not institution,						r Location of	Death		4c.	County of			
-			25214 Smith Land		e (In yrs. la	set hirthday)		Dento er 1 Year		1 Hrs. lo	. Date of Bi	rth	Care			- Fa-ai-m
	Funeral Director		5 Social Security Number 162–28–2985	1 M 2 F	74	Yrs.	Months		Hours	Min	(Month, D	av. Year)	- 1	Coun	lace (State or try)	r r-oreign
4	alter topic		Usual Residence of Decedent	~	/ 4					D	ecemse/	20,17.	02 11	arylo	ITEL	
	yland at		10a. State 10b. County		10c. City,	Town or Lo	cation		-					1	0d. Inside Cit	y Limits
	a-fsl	ctor	Maryland Caro	line	De	enton									1 ☐ Yes	2 No
	or 28)ire	10e. Street and Number				1	p Code				_	izen of Wh		-	
	23a ust b	Funeral Director	25214 Smith Lan	ding Road				1629							s of Ai	meric
	er deg	nue	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Dece If Yes, sp	edent of Hecify Cuba	lispanic Origii an, Mexican,	n? (Speci: Puerto Ri	y Yes or N can, etc.)	0-	 Race - Black, 	Americ White,		
2	s afte	by F	1 ☐ Never Married 2 ☐ MMarrie 3 ☐ Widowed 4 ☐ Divorced	ed 1.2 Yes 2 If Yes, Give Year or Dates:	No		1 ☐ Yes	2 No	Specify:				Specify:	Can	casian	
3	hour tural		15. Decedent			16a. Deced	dent's Us	ial Occur	nation			16h Ki	ind of Busi			
2	in 72 n "na Nedlo	plet	(Specify only highes	t grade completed)		(Give		ork done	durina most o	of working		100.11	ind of Buoi	1100071110	luouy	
7	with jiene r tha the A	Completed	Elementary/Secondary (0-12)	College (1-4or s	0+)	Self	emp	loyed	1			Bui	lding	COL	rtract	ол
2	othe /ent,	BeC	17. Father's Name (First, Middle, L	Last)					18. Mother's	s Name (I	First, Middle	e, Maiden	Surname,			
9	uld by Menta rked tic e	ToE	Rev. Tho	mas John Tw	rkingt	ton			Ju	anita	i Kath	rerin	e you	ıng		
2	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	'	19a. Informant's Name/Relationsh				-		and Number				-		,	20
2	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Memital Hygiene. If Health and Memital Hygiene from "natural", or items 23a or 28a-f show flem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Mary K. Turkin	gton Wife	,	L			Landing			enton	, Ma	ryla	nd 216.	29
5	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation	3 ☐ Removal from State	20b. Pla	netery crer	sition (Na	other place	ce)	Dat	е	20c. Lo	cation - C	ity or To	wn, State	
	ment ment tant: jury o		4 ☐ Donation 5 ☐ Other (Sp	pecify)	Ve				ery 6,	/12/2	2007	Hur	lock,	Ma	ryland	
מ	permit. Pages Department of Important: If It any Injury or o		21. Signature of Funeral Service L	icensee		22 M	2. Name a	and Addre \mathcal{F}_{II} n	ss of Facility	ome.	P.A.					
	20 = @ OI		4 Jamas	711/1008									n, Mo	ryli	and 21	
			23a. Part1. Enter the disease or shock, or heart failure. List	complications that caused only one cause on each li	the death.	. Do not ent	er the mo	ide of dyir	_	1		arrest,			Approximate Interval Betwonset and D	veen
F	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	-a. CONGE	5 L1	ue	ne	art	ra	ilo	re				2 year	5
ı	Examiner			Due to or as	a conseque	ence of):									1	
Ny T		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as	a conseque	ence of):										_
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events													
5	be executed sician and bunal-transit		resulting in death) Last	Due to (or as	a conseque	ence of):										
	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical		d												
5	death certificate b attending physic	Med	IF FEMALE:												_	
	ath ce ttendi	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal	death 3	Ectopic		у				23d. Date Mont		-	'ear
5	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant a 9☐Unknown	t time of dea	ath 5□	Other (s	pecify) _					WOIL		Day	cui
•	ires that the de signed by the a f be detached f		Part II. Other significant conditio	ns contributing to death b	ut not result	ting in the ur	nderlvina	cause giv	en in Part I.		23e. Did	tobacco u	se contrib	ute to th	e cause of de	eath?
֝֞֞֝֟֟֝֟֝֟֝֟֝֟	signe d be	d by					, 0				1 🗆	Yes 2	☑ No 3	☐ Prob	ably 4 □U	nknown
5	w requir been si should	Completed									24a. Was		24h W	are outo	psy findings a	wailabla
ַ ב	he lav e has ge 2	m									auto		pri	or to cor	npletion of ca	use of
	in: I		25. Was case referred to medical						00 84	1 D 1 - 1	1 Yes	2 X No	1 [Yes	2□ No	
> :	/sicia	o Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2□F	R/Outpatien		OA Oth	26. Place o er: 4 ☐ Nurs				e DOther	(Specifi	()	
5	g Phy er this eral o	n: To	27. Manner of Death	28a. Date of Inju	iry :	28b. Time of		28c. Injur Wor	y at		d. Describe				′)	
5	ath. rr: Aft	atio	1 Natural 5 Pending 2 Accident investig		y rear)	Injury	М		Yes 2 □ No	0						
2	or Attending Physician: the sifer death. Director: After this certificate he in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could no determine	nod Zoe. Place of III	ury - At hon	ne, farm, str	eet, facto	ry, office		28		(Street an		or Rura	l Route Numi	ber,
5	ital or rs afte ral DI led in	Cert			(ony or re		·			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	cal	(Check only 2 Medical E	g Physician: To the best Examiner: On the basis o	of my know f examinati	ledge, death on and/or in	n occurre vestigatio	d at the ti	me, date and opinion, death	place, an	d due to the	e cause(s	and man	ner as si	ated. the cause(s))
	the I	Medical	one)	and manner st	ated.		7 20	ac Licens	e number			20d Da	to signed	Month	Day Voor)	
1	2 w K		29b. Signature and title of certifier	l. O.	M			> CLOURS	127			290. Da	Signed (57	Day, Year)	
			30 Named	- 17 oces	looth (#	220) /T:	Drint\	12	172	ر ت		6		- 1		
			30. Name and address of person v	SIDES	920	Loa, (Type,	TA	ct	SE	2-1	evi	to	0 /	16	Day, Year)	29
	Sta		31. Date filed (Month, Day, Year)		ar's Signatu	ure	9									
	Registr	ar	JUN 11	ZUU/	100 1	JS /	200	Table 1								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 4:37 A.M **Physician** 06 2007 (nniE azewell 06 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Worcester Funder 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) HARTLEY HALL Nursing Home Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months 90 1 ☐ M 2 🗷 F 230-18-0574 01-30-1917 Director Usual Residence of Decedent 10d. Inside City Limits 10c. Gity, Town or Location 10a. State a 23a or 28a-f show 1 ≥ es 2 No oco Moke MORCESTER Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21851 1210 MARKET ST US.A 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) LEVET IN THE IN 11. Marital Status Black, White, etc. Pages 1 and 2 should be tiled within 72 hours after 1 ☐ Yes 2 ₹No If Yes, Give Year or Dates: Specify: Black 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 □ Divorced "neturel" 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. Item 27 is marked other than "netur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Private Family Home College (1-4or 5+) Elementary/Secondary (0-12) JOMESTIC BYH 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be HEnry azewell Mora Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) hewis DE Joyce McCou - NIECE 20453 Old Metal Lr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) John Wesley Cemeters 06-09-07 Westover, 22. Name and Address of Facility to thony E. Ward Funeral Heme 21. Signature of Funeral Service Licensee 30039 Hampden Ave Princess Anne, MD 21853 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final no car Physician disease or condition resulting in death) /Medical Due tour as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate or Attending Physicien: 26. Place of Death Check onl. one funeral director, 25. Was case referred to medical examiner? Hospital: Other: 4K Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No after death. investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by 4 Homicide within 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Fo the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 054422 June -06-2007

3EA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

JUN 0 7 2007

32. Registrar's Signature

ORIGINAL

State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Thorn ton Month 05 955 **Physician** ana /Medical 4a. Facility Name (If not institution, give street and pumber) 4b. City, Town, or Location of Death 4c. County of Death Examiner 501150114 NICIMILO GNIN SYLVA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 5/31/2007 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days Maryland 213-11-4656 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Salisbury Wicomico Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21804 USA 506 Emory Court, Apt. 303 · death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. African/ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ American 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry it of Health and Mental Hygiene. If Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a n/a n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Shawla Renee Sledge Dana Lynn Thornton, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 506 Emory Court, Apt. 303, Salisbury, MD 21804 Shawla R. Sledge/mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 5 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once, 6/4/07 Salisbury, MD Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
Holloway Funeral Home, Professional Association 23a. Part. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter uncoming Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 2 No certificate 1□ r this certifica 25. Was case referred to medical examiner? 26. Place of Death Check onl one 2 No Other: 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA မှ 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death 1 Natural 28c. Injury at Work? Medical Certification: (Month, Day Year) Injury 5 Pending investigation within 24 hours area

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ပ္ 5/3//2007 D36589 physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Woods E. Carroll St. John 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JUN 04

2007

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per th 869 -26-07 vt. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** MARILYN ROBERTS WYRE 6:10AM June 10 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3617 Dublin Road Darlington Harford If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Securit 6776 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F 7/20/1957 Director 219-70-6766 49 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other then "natural", or items 23a or 28a-f show other traumetic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Director MD Harford Darlington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3617 Dublin Road 21034 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2X No White Specify: Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Service Representative Communications 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be 1 nent of Health and Mental I Buck Truman Roberts, Sr. Joan Crowther 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Wyre/Husband 3617 Dublin Road, Darlington, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: if it
ony injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Eagle Crematory 6/11/2007 Leola, PA 21. Sign Jure f Funeral Service Lic 22. Name and Address of Facility Int. Enter the disease, or combilications that caused the realth. Do not enter the mode of dying, such as cardiac or respiratory arrest, flate Cause (Final Harkins Funeral Home, Inc., Delta, FA 17314 Approximate Interval Between Onset and Death mediate Cause (Final disease sever **Physician** disease or condition resulting in death) /Medical Due to (or as a conse quence of) **Examiner** NT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner rsician and 3 burial-transit Due to (or as a consequence of): the attending physician thed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) Yes 2 No detached 9 Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? À 1 Tyes 2 No 3 Probably 4 Unknown Completed peed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Ho has page 2 autopsy performed? this certificate 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 2 1 Yes 2 16 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Juleath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 4 atural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director 3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide hours after 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 To the 29d. Date signed (Month, Day, Year)

State Registrar

12

29b. Signature and til

IJAY.S

JUN 1 8 2007

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

deeth with the Maryland

Baltimore, Maryland 21215-0036

3

Hospital or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

source

602.5

trendence

M.1)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

-NAIR

June 11th 2007

Belain MD 21014

16444

AtwoodRd

			1 - For State Registrar	State of	Marylan		artmen			and M	lental Hy	giene	2007	19632
			Decedent's Name (First, Middle, Last,)							2. Date of De	ath		3. Time of Death
	Physici		WILLIAM E. WEAVE	R							Month June	Day	Year 2007	7:00 A M
}	/Medic Examin		4a. Facility Name (If not institution, give	street and numb	per)		4b. City,	Town, or	Location o	f Death	0 00.10		County of Dea	
			Madonna Heritage,	Inc.			Jar:	rett	svill	.e			Harfo	rd
	Funeral		Social Security Number 6. Security Number		. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under 2	24 Hrs. Min.	8. Date of Birt	h v. Year)	9. Bir	thplace (State or Foreign
	Director		230-14-3113]M 2□F	90	Yrs.	WOTHIS	Days	Tiours		2/15/19	917"	Nor	th Carolina
	pue A		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation							10d. Inside City Limits
	faryli sho	ō	MD Harford			rretts								1 ☐ Yes 2 No
	28e-	ect	10e. Street and Number				10f. Zip	Code				10a Citi	zen of What Co	nuntry?
	with be or	<u></u>	3982 Norrisville R	hso			,	084				rog. o.k.	USA	Surrily .
	Jeath The 20	Funeral Director	11. Marital Status	12. Was Deced	ent Ever in U.	.S. 13. \			spanic Orio	nin? (Spe	ecify Yes or No		14. Race - Ame	erican Indian,
က	or Iter	F	1 Never Married 2 Married	Armed Force 1 Yes 2 If Yes, Give			f Yes, spec	rify Cubar	n, Mexican	, Puerto	Rican, etc.)		Black, Whit	te, etc.
Š	reif, c	þ	3√ Widowed 4 □ Divorced	If Yes, Give Year or Date	es:		I□Yes 2	2LXNo	Specify:				Specify: W	hite
5-0	n 72 hours after death with the Maryland *neture!; or Iteme 23a or 28e-f show adical Examinar must be notified at	Completed by	15. Decedent's Edu (Specify only highest grad			16a. Deced	ient's Usua	l Occupa	ition	of worki	na	16b. Ki	nd of Business	/industry
21	ithin ner	фr	Elementary/Secondary (0-12)	College (1-4	lor 5+)	1	kind of wor DO NOT us					7		
2	lygier her ti	õ	10			Mac	hinis	t			4000		motive	
and o	be fi	Be	17. Father's Name (First, Middle, Last) Ross Weaver								(First, Middle,		Sumame)	
ž	d Mel d Mel nark	2	19a. Informant's Name/Relationship (Ty	no Print)		10h Mailie	- Add	/Careat a		`	unknowr		T C4-1-	7. 0. 1.1
Maryland 21215-0036	permit. Pages 1 end 2 should be filed within Deperment of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Magnete.		Linda L. Miller/	-	r						<i>Route Numbe</i>			
စ်	1 en Heal tem 2		20a. Method of Disposition	Daugite	20b. P	lace of Dispo	sition (Nam	e of	1	-	attscor		cation - City or	
2	t: If if		Murial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	lemoval from St	aie !	emetery, cren Vernoi			·	/15/	2007		eford,	
Baltimore,	ortan		21. Signatur of Funeral Service Licens	ee 1	1		. Name and				200.	******	,01010,	
ä	Depe Impo any is		Elelin P.	Low	eled						, Inc.,	De1	ta, PA	17314
			23 Part 1. Enter the disease, or compl	eations that cau	sed the de									Approximate
	Physician	. 11	shock, or heart failure. List only or Immediate Cause (Final		a Star	fic .		m 40	0	Dicc	enom	a.	19	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		as a consequ		NUS	un	_ (110	Crioni			- 11
	Examiner		Convention the time and distance),										3 months
	D ≃	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	uence of):								
du	acute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last											
8760,	ate be executed hysicien and the burial-transit	<u>a</u>	resulting in death / Last	Due to (or	as a consequ	uence of):								
87	icate be executed physicien and s the burial-transit	Physician/Medical		l										
9 X	ding se as	/Me	IF FEMALE:	3c. If yes, outco	me of pregna	incv								
Вох	eath etten for u	cian	in the past 12 months?	1 Live birtl	h 2 ∏ Fetal	death 3	Ectopic pre					2	3d. Date of del Month	Day Year
P.O.	the d y the ached	ysi	1 ∐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow		Jun 5 _	TOTTION (Spe	,y						
<u>σ</u>	es thet the death certific igned by the ettending p be detached for use as	by Pi	Part II. Other significant conditions cor	tributing to deal	th but not resu	ulting in the un	derlying ca	use give	n in Part I.		23e. Did to	obacco u	se contribute to	the cause of death?
rds	v require been sig should b	pe pe									1 🗆 Y	′es 2[]No 3□Pr	obably 4 Unknown
တ္တ	aw requir s been si 2 should	piet									24a. Was		24b. Were au	utopsy findings available
æ	The Ite ha	Completed										rmed? 2 XNo	prior to death?	completion of cause of 2□ No
ā	ian: ntifica ctor, p	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o		10.103	20110
Ž	hysic his ce I dire	2	1 ☐ Yes 2 No	lospital: 1 🗌 Inp	atient 2 🗆	ER/Outpatien	3 DO	A Othe	r. 4 Nur	sing Hor	ne 5 ☐ Resid	ience 6	☐Other (Spe	cify)
_	ng P	6	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	28	Bc. Injury Work	at ?	2	28d. Describe h	ow injury	occurred	
Sio	tend leath. tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be				М		es 2□N	10				
Division of Vital Records,	l or At etter o Direct I in by	Certification;	4 Homicide determined	28e. Place of building	Injury - At ho , etc. (Specify	me, farm, stre	et, factory,	office		2	28f. Location (S City or Tow		Number or Ru	ural Route Number,
	pitel ours e eral [ပ္	29a. Certifier 1 Cartifying Phys	violent Te the b		- 1								
	Hos 24 hc Fun stely	edicai	29a. Certifier 1 Cartifying Phys (Check only one) 2 Medical Examin	nar: On the basi and manner	is of examinal	wiedge, death tion and/or inv	estigation,	in my op	e, date and inion, deat	n piace, a	and due to the o	date and	and manner as place, and due	stated. to the cause(s)
	To the Hospitel or Attending Physician: The law requires that the death certific within 24 hours elected at the centificate has been signed by the ettending p completely filled in by the funeral director, page 2 should be detached for use as a	Me	29b. Signature and title of certifier	50	(. N	29c.	License	number			29d. Date	signed (Mont	h, Dey, Year)
)	->-0		May (Ma	IG N.		7	000	545	73	,	(11110	7
		}	30. Name and address of person who co	mpleted cause	of death (Item	23a) (Type. I	Print)	^	114	7	1	- · · ·	111	7.08.
	V		Mary E. Yva	19 MD	3	718C	Nov	Y159	1 lle	KO	l Java	P#	SVIC	MU HOOG
	Sta		31. Date filed (Month, Day, Year)	32. Reg	istrar's Signa	ture done	()							
	Registra	ar	JUNI & ZUU/	10000	JU.	1	100							

INIIIam E. Weaver

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** WHITSETT .TR. FIMER /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES LANHAM DOCTORS HOSPITAL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Min. Months Days Hours 1**™** M 2□ F 19 1942 Director 579-54-2012 64 DEC NORTH CAROLINA Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10b. County Show r than "natural" or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Director MD PRINCE GEORGE'S LANHAM 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20706 5510 BELVA PLACE by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 X Married 1 ☐ Yes 2K No BLACK Specify: 21215-0036 Specify: Year or Dates: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) PRIVATE ASSISTANT SUPERINTENDANT yrs other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland s 1 and 2 should be fill Health and Mental H tem 27 is marked oth Be PEARL MAY WILLIAMS ELMER WHITSETT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5510 BELVA PLACE LANHAM, MARYLAND BARBARA WILLIAMS WHITSETT Baltimore, If item or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition perr it. Pages 1 Department of H Important: If ite any injury or otl 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify RIVERDALE CREMATORY 6/1/2007 RIVERDALE, MARYLAND 22. Name and Address of Facility 21 Signature of FuperatiService Lic J. B.JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. art1. Enter the disease, o shock, or heart failure. List mmediate Cause (Final disease or condition resulting in death) Physician nenthy /Medical **Examiner** yen Sequentially list conditions, if any leading to him lead cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Physician/Medical the as attending properties for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 🗆 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a. Was an cate has t page 2 s autopsy perform certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No 1 Unpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Box 68760, P.0. Division or Vital Records,

Hospital or Attending thin 24 hours arren co. A the Funeral Director: A

2 State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

5 2007

and manner stated.

29d. Date signed (Month, Day, Year)

DOO34722 6-1-20
Print)
Bladles Gorg, Ml. 20110 dress of person who completed cause of death (Item 23a) (Type, Print) Name and

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 15 AM **Physician** Sallie May Wells June 1, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Magnolia Center Lanham 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 🗆 M 11/06/1913 Director 578 50 5499 93 Virginia Usual Residence of Decedent the Maryland r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No prince Georges Clinton Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code o e Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. iner must b 20735 United States 8600 Mike Shapiro Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Black Specify: 3€ Widowed 4 Divorced Year or Dates: Completed er than "natur the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry 9th Domestic Worker 27 is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pleasant Oliver Graves Sadie Bowers မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Wells/Son 10902 West Kettering Dr., Largo, MD item 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 ☐ Burial 2 Tremation 3 ☐ Removal from State Riverdale Crematory 06/05/2007 Riverdale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John T. Rhines Funeral Home, LLC 21. Signatui uneral Serv 3015 12th St., NE Washington, DC nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. 23a. Part1. shock neart Immediate ause (vidisease or condition temoscre **Physician** 12913 resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed physician and s the bunal-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical as attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1345 motile 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe androme 2 □ No 1 ☐ Yes Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

within 24 hours after death

To the Funeral Director:
completely filled in by the To the Hospital

State Registrar

29b. Signature and title of certifier

29c, License number

29d. Date signed (Month, Day, Year)

Wainsbury Ad Hyartsville MD2078

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

31. Date filed (Month, Day, Year) JUN 0 5 2007

(Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day 2007 Year Month Physician June 1, Warthen 10:40AM Doris /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Thurmont 817 Woodland Avenue If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, March 2, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💁 F Months 214-36-0887 68 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
Inst: If item 27 is marked other than "natural", or Items 23a or 28a-f show with: If item 27 is marked other than "natural", or Items be notified at ury or other traumatic event, the Medical Examiner must be notified at 1471Yes 2□No Director Thurmont Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21788 USA 817 Woodland Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐ Yes 2 Yes, Give 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ð Specify: 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Teacher's Aide Public School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Favorite Stambaugh Ethel Maurice 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 817 Woodland Avenue, Thurmont, MD 21788 David Warthen/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1X Burial 2 ☐ Cremation 3 ☐Removal from State 6/6/2007 Blue Ridge Cemetery Thurmont, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ${\sf Stauffer}$ Funeral Home, ${\sf PA}$ Signature of Funeral Service Thurmont, MD 21788 11. Enter the disease, or ock, or heart failure. List Approximate Interval Between Onset and Death ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, results on each line. Immediale Cause (Final **Physician** disease or condition resulting in death) /Medical ence uf) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached Division or Vital Records, P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s autopsy performe 1∐ Yes 2 1 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1-Natural 5 Pending investigation after death.

I Director: A
d in by the fu 1 🗌 Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral C completely filled i 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

ס

State Registrar Name and ad

Thomas Johnson

07-04006 Gua

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

am Washingt		State of Maryland / Department of Heal -For State Certificate of Deat		Mental F		Reg. No.	200	7 1953
Physici edical Exami	an/	legistrar 1. Decedent's Name (First, Middle, Last) GUAM LOUISE WASHINGTON			2. Date of Dea Month May 26, 2	ath	Year	3. Time of Death 2003 hrs
		The state of the s	Town, or Loc e de Grac	cation of Dea			ounty of Death ford	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Und Montr	-	If Under 24H Hours Mi	n	04/195	Foreig	hplace (State or n untry) MARYLAND
япу		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				717 170		10d. Inside City Limits
≥	.to		E DE G	RACE	1.3	10a. Citizen	of What Cour	1 X Yes 2 No
h the Mar 3a or 28s	Director	557 GIRARD STREET	21	078			USA	Α
er death witi , or items 2	Funeral	1 Never Married 2 Married Armed Forces? If Yes, special Yes 2 X No		lexican, Puer	Specify Yes or N to Rican, etc.)		White, etc.	can Indian, Black, BLACK
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene and the filed Pharmet is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	I Occupation orking life. DO	(Give kind o O NOT use re			of Business/I	
21215-0036 21215-0036 July be filed within 7 I Mental Hygiene. marked other than ic event, the Medica		12 DON 17. Father's Name (First, Middle, Last) NATHANIEL WASHINGTON	1		me (First, Middle,		TVATE F	IOMES
D 212: should be and Mental is marke	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addres	s (Street ar	nd Number o	r Rural Route Nu			
Baltimore, MD pernit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumati		20a. Method of Disposition 20b. Place of Disposition (Na crematory or other place	ame of cemet e)	tery,	Date	20c. Loc	ation - City or	
Baltimo permit. Page Department (Important: injury or ott	l	4 Donation 5 Other Specify: R.A. FERRIS & 21. Signature of Funeral Service Licensee	d Address of	Facility TFUNE	/7/07 TRAL HOM	E. P.A	CHEST	
Physician /Medical		23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode failure. List only one cause on each line.	LEWIS	STREE	T, HAVR	E DE C	RACE	MD 21078 Approximate Interval Between Onset and Death
caminer		Immediate Cause (Final disease or condition resulting in death) a. Chronic Alcohol Abuse Due to (or as a consequence of):			<u> </u>			
Į.	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated						
and and transit	al Exa	events resulting in death) Last Due to (or as a consequence of): d.						
50, te be execut ystcian and burial - tra	ledical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy				23d. [Date of deliver	v
Box 68760 c death certificate b the attending physi cd for use as the bu	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unknown 1 Unknown		Ectopic preg	gnancy			Day Year
™ ₽ ™	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause give	en in Part I.		pussering	-	the cause of death?
Par la S	Completed				_ per	s an opsy formed?	24b. Were at prior to death?	utopsy findings available completion of cause of
LE		25. Was case referred to medical	26.Place of	f Death (Che				
Vita hysicia: this cer	To Be	1 Ves 2 No	2011		rsing Home 5	Residenc		г:
<u> 7</u>		27. Manner of Death 1 ✓ Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		s 2 No	28d. Describ			
Division • Hospital or Attendidate to 1.24 hours after death. • Funeral Director: A etely filled in by the fi	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factor (Specify)			or Town	, State)		ural Route Number, City
To the Hos within 24 h To the Fun	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in rand manner stated.	my opinion, d	death occurre	and due to the ca	te and place	, and due to the	ne cause(s)
	Ž	29b. Signature and title of certifier	O.C.M				27, 2007	onth, Day, Year)
2		30. Name and address of Jerson who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street	eet, Baltin	more, MD	21201			
S Regi	tate strar	31. Date filed (Month, Day, Year) 32. Registrar's Signature						

Registrar DHMH 17 Rev 1/2001 OCME 2006

		-	For Slate Registrar	State	of Maryla		artment of F rtificate of			giene Reg. No.	0.07	10007
			Decedent's Name (First, Middle	e, Last)					2. Date of De	ath	U 	3. Time of Death
	Physicia		Garnet Lee Whit	reaker					Month May	31	Year 2007	9:10 A ^M
	/Medic		4a. Facility Name (If not institution		umber)		4b. City, Town, o	r Location of Death			ty of Death	3,120 22
J	⊏xamın	er	757 McCauley Ro	_	,		Conow				eci1	
Act.	Funeral		5. Social Security Number	6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th av Year)	9. Birth	olace (State or Foreign
	Director		226-18-6023	1 ∑ M 2□F	86	Yrs.	WOITE Days	Tiodis Will.	Feb. 6		000	Virginia
P	@		Usual Residence of Decedent		140-6	V. T						104 1-14-00-11
ırylar	show I at	_	10a. State 10b. County		100.0	City, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 No
e We	3a-f	cto	Maryland Ceci	1		Conow						
it th	or 2	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o		ntry?
ath w	23a ust b		757 McCauley R			,		918		US		
G Z IZIS-UUSO filed within 72 hours after death with the Maryland	of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	Funeral	11. Marital Status	Armed F		U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)		ace - Ameri lack, White,	
s affe	or i	by F	1 Never Married 2 Married	ried 1 1 1 1 Yes If Yes, 0	2 □ No Bive		1 □ Yes 2 X No	Specify:		Spec	cify: T.	Thite
S non	uraľ,		3 Widowed 4 Divorced		Dates: WV	VII	dent's Usual Occup	antin-		16b. Kind of		
Z 1 Z 1 3-0036 ed within 72 hours af	"nat	Completed	(Specify only highe	t's Education st grade completed	1)	(Give	kind of work done DO NOT use retire	during most of work	king	100. Kiliu ol	DUSINESS/II	idustry
j j	than than	립	Elementary/Secondary (0-12)	College	(1-4or 5+)	Mech		ω,		Gover	nment	
lled N	Ther it t	ပိ	17. Father's Name (First, Middle,	Last)		Hech	anic	18. Mother's Nam	ne (First, Middle	1		
and l	Mental I arked or atic eve	Be	Frank Harrison		. 22				Jane Pu		,	
aryla	d Me nark natic	ဥ	19a. Informant's Name/Relations			19h Maili	ng Address (Street				n State Zi	n Code)
Maga d2s	than 7 is t traus						North Pa					ŕ
e, €	of Health and Ment I Item 27 is marked r other traumatic e		Frederick Whea 20a. Method of Disposition	ton/steps			osition (Name of matory or other pla		Date Date	20c. Locatio		
Pages	or o		1 X Burial 2 ☐ Cremation		n State						-	
1 P. P. S.	rtmer rtant		4 Donation 5 Other (5		We		tingham C		-2007	Colora	, Mar	yıand
Baitimore, Maryiand permit. Pages 1 and 2 should be file	Department important: if any injury or once.		21. Signature of Funeral Service	Licensee	12	R	. T. Foar	d Funera	1 Home,	P.A.		_
			Kuchaid	r. G	rque	, <u> 1</u>	11 S. Que	en St.,	Rising	Sun, MD	2191	
		Ш	23a. art1 Enter the disease, o shoch, or heart failure. Lis	t only on a carre or	each ne.	ath. Do not en			or respiratory	arrest,		Approximate Interval Between Onset and Death
	ysician		Immediate Cause (Final disease or condition resulting in death)	_a Ct	REMEOV,	4541 pm	- Hure	7				
100	Medical caminer		resulting in death)	Due t	o (or as a cons	equence of):						
_^	Cammer		Sequentially list conditions	b	EMER	JIM						
p ₀	sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due t	o (or as a cons	equence of):						
1876U, cate be executed	physician and the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due t	o (or as a cons	equence of):						
876U, sate be ex	cian	É	,	Due	o (oi as a cons	equerice oi).						
87 ate	physic the b	dical		d								
ertific 6	attending p	a a	IF FEMALE:	000 16								
BOX eath cert	ttend or us	ian/	23b. Was decedent pregnant in the past 12 months?	1 ☐Liv	outcome pf prede birth 2 1 F	etal death 3	Ectopic pregnanc	:y		- 1	Date of deliv Month	very Day Year
. e	by the a	sic	1 Yes 2 No 9 Unknown	4⊟Pre 9⊡Unl	gnant at time o known	r death 5	Other (specify) _					•
I Records, P.O. Box 6 The law requires that the death certifi	d by letacl	by Physician/M	Part II. Other significant condit	lone contributing to	death but not r	esulting in the	inderlying cause di	ven in Part I	23e Did	tohacco use c	ontribute to	the cause of death?
Vital Records, sician: The law requires t	signed I be det		Tarri. Other signmount condit	ions contributing to	dodar bat not i	country in the	maonymy addoo gr	on with dark in		Yes 2□No		bably 4 Gonknown
o nbe	been si	Completed								7.00	00,10	
ec § § §	S C4	βl							24a. Wa	opsy	prior to o	opsy findings available ompletion of cause of
	ate	ပ်							per 1□ Yes	formed? 2 100	death? 1 □ Yes	2 40
/Ita	is certificate ha director, page	Be	25. Was case referred to medica examiner?					26. Place of Dea	ith (Check only	one)		
hysi	his o	2	1 □ Yes 200 No	Hospital: 1[Inpatient 2	☐ ER/Outpatie	TIL SLI DOA		lome 5 Ae	sidence 6 🗆	Other (Spec	rify)
o P P	After this funeral di		27. Mann Death 1 atural 5 ☐ Pendi	/8.6	te of Injury onth, Day Year,	28b. Time Injury	of 28c. Inju Wo	iry at rk?	28d. Describe	how injury oc	curred	
DIVISION OF i or Attending Phys	er death. rector: After th by the funeral	ertification:	2 Accident invest	igation				Yes 2 No			-	
¥ ĕ	irect irect	ij		night 200. Fid	ice of injury - At ilding, etc. (Spe	t home, farm, s ecify)	reet, factory, office		28f. Location City or T	(Street and Nu own, State)	mber or Ru	ral Route Number,
ig C	rai D	O										
DIVISION OF VITA To the Hospital or Attending Physician:	within 24 hours after death To the Funeral Director: completely filled in by the	cal	(Check only 2 Medica	ng Physician: To	e basis of exam							
the	within 24 To the F complete	Medical	one)	and m	anner stated.							
2	70 CO.	2	29b. Signature and title of certifi	er A			29c. Licen	Hall =		29d. Date sig	med (Month	i, vay, rearj
•			P 1144 51	M M.1)				107/		5/3	110+	
1	10+IVA		30. Name and address of person	who completed ca	use of death (I	1 1	, Print)	HD/	M. A	21079	,	
			Hi sup 1 41	A 317	> .	WHION	MUL	H176	W D	70+5		
	Sta		31. Date filed (Month, Day, Year	7 107 A 32	. Registrar's Si	gnature	W					

07-04402 Gary Lee White Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lease	lype or Print in Di	ack illucione illik.	Lilouitin	
icuse	State of Maryland	/ Danastmont of L	calth and Mental	Hygiene
	State of Marviano	/ грерапиченког п	eaith and Monta	11,9.0

Lee White		State of Maryland / Department of Health and IV I-For State Certificate of Death	nemai mygien		2001 203					
	F	Registrar	2. Date	Reg. No.	3. Time of Death					
Physicia ' Examir		1. Decedent's Name (First, Middle, Last) CARU Let While	Mon Jun	th Day e 8, 2007	Year 1956 hrs					
Exami		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Loca		4c. 0	County of Death					
		8541 Fontaine Road Manokin			merset					
Funeral		5. Social Security Number 6. Sex 7. Age (III yis last bit itagy)	f Under 24Hrs. 8. Da	ate of Birth(MM/DI	l-oreign					
Director	-	219-60-1121 1XM 2 F 50 Yrs. Months Days	Hours Min.	1-13-195	Country) MD					
	H	Usual Residence of Decedent			10d. Inside City Limits					
any		10a. State 10b. County 10c. City, Town or Location			1 Yes 2 KNo					
nd show	님	MD Domerset WestouER		10a Citiza	en of What Country?					
Aaryla 28a-f 1 at o	Director	106. Street and Number 107. Zip Code 218	71	109. 0.1.2	100					
death with the Maryland or items 23a or 28a-f show any must be notified at once.		OJOU TOLEHAANIE CYTUTOT TOUS		es or No-	14. Race - American Indian, Black,					
h with	Funeral	Armed Forces? If Yes, specify Cuban, M	fexican, Puerto Rican		White, etc.					
r death w	Ξ	1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No s	specify:		specify: Black					
rs afte	by	Wildowed 4	(Give kind of work do	one 16b. K	ind of Business/Industry					
2 hou "nat	etec	Elementary/Secondary (0-12) College (1-4 or 5+)		A	to Mechanic					
1036 vithin 72 hours afterene. ere than "natural", Me lical Ex. miner	Completed	12th Laborer	.Mother's Name (First	1						
21215-0036 Muld be filed within 72 hours after Muntal Hygiewei namked other than "natural", ic event, the Medical Examiner.		17. Father's Name (First, Middle, Last)	Esther 1		Johnson					
21215-(uld be filed unarked oth c event, the	Be	10h Mailing Address (Street a	and Number or Rural	Route Number, Ci	ty or Town, State, Zip Code)					
Baltimore, MD 21215-0036 Degrmit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is narked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner.	2	Brenoa White - Wife 8306 mennonite	Church R	10 West	HOURY, MD 218/11					
re, MD s 1 and 2 sho if Health and If item 27 is		20b. Place of Disposition (Name of ceme	etery, Dat	e 20c. i	Location - City or Town, State					
nore, MD 2 ages I and 2 shount of Health and Nt: If item 27 is not other traumatic		1 Burial 2 Cremation 3 Removal from State crematory or other place)	010-16	- 2007 5	Salisbury, MD					
Baltimore, permit Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of	of Facility Antho	ny E. Ma	Dalisbury, MD					
Bal Bermi Depar Impo injur		1 (C. U. m. A. 1) and 1 (30/29 Hamed	en AUG Kri	ncess And	re, MO 04853					
hysician	<u> </u>	Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, su	uch as cardiac or res	oiratory arrest, she	Between Onset and					
Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Hyperthermia			Death					
≟xaminer		or condition resulting in death) Due to (or as a consequence of):								
	7	Sequentially list conditions, If any, leading to immediate Due to (or as a consequence of):								
	nin	cause. Enter Underlying Cause C. C. C. C. C. C. C. C. C. C. C. C. C. C								
od Sit	Examiner	events resulting in death) Last								
O, be executed sician and burial - transit	7		0/07 777							
50, te be ex ysician burial			_	23	3d. Date of delivery					
6876(certificate ading phy	1/00	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy		Month Day Year					
Ox 6876(leath certificate e attending phy-	Dhyeirian/M	past 12 montris? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown								
BOX he death cy the attenty the detenus	غ ا	Part II. Other significant conditions contributing to death but not resulting in the underlying cause gi	iven in Part I.		o use contribute to the cause of death?					
, P.O. rres that the signed by	1			1 Yes 2 No 3 Probably 4 Unkn						
rds, l	1	26.Place		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of					
aw re	5			performed	? death?					
Rec The I		26 Place	of Death (Check only							
ician: The law is certificate has be	unction, page	- 1 25 Was case referred to medical	Other Nursing H		dence 6 Other: Scene					
> % E		O 1 V Yes 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injur	ry at Work? 28	d. Describe how i	njury occurred high environmental					
n of ding Pl h.	e iniiciai	Natural 5 Pending Impe 8, 2007 FVd 8:42 pm	Yes 2 TNO .	-	20					
ivisior or Attendafter death Director:	oy me	Pending 2 X Accident 3 Suicide 6 Could not be Spending Investigation 28e. Place of Injury - At home, farm, street, factory, office be	ouilding, etc. 28	f. Location (Stree	t and Number or Rural Route Number, City					
Division lospital or Attendit thours after death.	uilled in	determined (Specify) in car			ne Rd. Manokin, MD					
2 - =			ate and place, and du	ue to the cause(s) he time, date and	and manner as stated. place, and due to the cause(s)					
To the He within 24	completely	and mariner stated.		1 29	id. Date signed (Month, Day, Year)					
F * F	٥		.M.E.	I	une 9, 2007					
		La resolit Stilleville, MM								
		30. Name and agdress of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
		Familie L. Coodinati, in San Noorl 32 Regulatrar's Signature								
Rec	Sta jistr	are of Date filed (Month), 1997, 1997								

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

OCME

State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistras Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** earn If Under 24 Hrs. uture TIMORE are If Under 1 Year 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) **Funeral** Months Days Min. -22-8690 1 □ M 2 X F Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits marked other than "natural", or iteme 23a or 28a-f ahow umatic avant, the Medical Examinar must be notified at 1 XYes 2 No Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death 1 Hygiene. Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Ď 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill treent of Health and Mental H lent: If Itam 27 is marked other 19a. Informant's Name/Relationship (Type, Print) (nephew) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Showden 27/3 N.7 | 20b. Place of Disposition (Name of 2 20c. Location - City or Town, State Date 20a. Method of Disposition cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State permit. Page Depertment of Importent: If any injury or once. 20 4 Donation 5 Other (Specify) torest 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph W. North Ave. Baito 23a. Parl . Enter the "sease, or complica ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart follure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical Examiner as a neequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ned by the e 9 Unknown 9 Unknown cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 2□ No 2ŪNo 1 Yes 1 Tyes To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} \) within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M12 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St Sute 308, BALTIMORE MP 82 N. EUTAW 1 mos 2+17 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUN 1 9 2007 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ranice Atkinson	1- For Regist	State Amei	nd #10f	of Maryland Per FH G8	Depart	ificate of De	aith an ath	o Mentai n	ygierie _{Re}	eg. No.	007 1961
Physician/ Medical Examine	1. De	cedent's Name	(First, Middle,Las	111/	150n				2. Date of Deat Month June 11, 2	Day Year	3. Time of Death 1925 hrs
		acility Name (if		ve street and number			y, Town, or Itimore	Location of Death	1	4c. County o	f Death
Funeral Director	5. So	cial Security Nu			ge (In yrs. las	Mo	Inder 1 Yea			th (MM/DD/YYYY)	Foreign
		Residence of	Decedent	M 2 X F	40	Yrs.			11 /0.	2/66	Country) M.D
nd show any	10a. State 10b. County 10c. City, Town or Location Baltimore								10d. Inside City Limits 1 Yes 2 No		
ne Maryland or 28a-f show fied at once.	10e. S	Street and Num		1			Zip Code			Og. Citizen of Wh	at Country?
r death with the Maryland or 18a-f shanus 23a or 28a-f shanust be notified at onc	11. M	28 16 larital Status	Clifton	12. Was Deceden	t Ever in U.S			spanic Origin? (S			- American Indian, Black,
		Never Marrie		Armed Forces 1 Yes 2 If Yes, Give Year	X No	1 Yes		n, Mexican, Puerto specify:	Rican, etc.)	White Specify:	Black
2 hours aft "natural" Examine	15. I	Decedent's Edu		only highest grade col College (1-4 or	. ,	16a. Decedent's Us during most of		ition (Give kind of e. DO NOT use ref		16b. Kind of Bus	
5-0036 ed within 72 hour lygene. other than "natu the Medical Exan	17.5	H_		0	,	Cosme	0/09		o /Finnt Stiddle S		-employed
21215-0036 hould be filed within 7/ hould be filed within 7/ is marked other than utic event, the Medical To Be Comple	ם ו	Erne:		7+Kinson)				a G	ary	
MD 21215-0036 and 2 should be filed within 7 the and Mental Hygiene. m 27 is marked other than aumatic event, the Medica To Be Comple	19a. I	Informant's Nar 5 Erne	ne/Relationship (Type, Print)		19b. Mailing Add	Iflon	et and Number or Auenu noce	e	,	n, State, Zip Code)
Baltimore, MD 21215-005 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med To Be Comi	20a. I	Method of Disp Burial 2		Removal from S	ate o cr	ace of Disposition (ematory or other pl	Name of ce	metery,	Date	20c. Location -	City or Town, State
Baltimore, permit. Pages I ar Department of Hea Important: If iter injury or other tr	21. Si		Other Specify eral Service Lice		Tree	22 Name	and Addres	1= 4:	128107 [H. P.A	Daltin	nore, MD
m ឧក្សន្ត Physician	23a. F	Part I. Enter the	e disease, or com	plications that caused	the death.	222	2 11	V. North	Avenue	est, shock, or hea	rt pproximate Interval
Medical. xaminer	Imme	diate Cause (F		Complicat	ions of	narcotic (nethado	one, morph	ine, and p	ropoxphene	Between Onset and Death
	Sequ	or condition resulting in death) Due to (or as a consequence of): intoxication Sequentially list conditions, b.									
ted Insit	cause (Dise	r, leading to imre. Enter Under	lying Cause at initiated c	Due to (or as a cons				_11_			
cecuted t and transit	eveni	ts resulting in d	d						_		
760, cate be execut physician and he burial - tra	IF FE	UNPENDED MALE:		#23a,27,28 23c. If yes, outco	Ba-f, pe	erME, g868,	6/22/0	07 TT		23d. Date of	delivery
9.O. Box 68760, that the death certificate be executed ned by the attending physician and detached for use as the burial - transit by Physician/Medical Ex	23b. W	Vas decedent p ast 12 months?	?		t time of dea	2 Fetal de		Ectopic pregn	ancy	Month	Day Year
O. Bo at the dea by the a tached fo			icant conditions	n 9 Unknown contributing to dea	th but not res	sulting in the underl	ying cause	given in Part I.	23e. Did to	obacco use contri	bute to the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the star of earth. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Be Completed by P.	(ng) -				-0				1 Yes		Probably 4 Unknown Vere autopsy findings available
Records, The law requires freate has been sig., page 2 should be	-	· · · · · ·				<u>-</u>	····		autop	rmed? d	rior to completion of cause of eath? Yes 2 No
tal Riciant Ticiant Ticertifica	25. W	/as case referre kaminer?		Hospital: 1 ✓ Inpati			_	e of Death (Check	only one)	house of	
of Vi g Physi fter this neral dir	27 M	Yes 2		28a. Date of Inj (Month, Day,		ER/Outpatient 3 28b. Time of Injury	DOA 28c. Inju	ury at Work?		Residence 6 how injury occurre	Other:
tendin Heath. Hor: A	1 2	Natural Accident	5 Pending Investigat	umk	rear)	unk	1	Yes 2 X No	unk		_
Division of Vital Records, P.O. Box 68760, To the Hospital or After the Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transledical Certification: To Be Completed by Physician/Medical E-	3 4	3 Suicide 6 X Could not be determined (Specify) Unk 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Route Number or Town, State)								er or Rural Route Number, City unk	
To the Hosp within 24 hor To the Func completely fi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
To with To con	29b. 8	Signature and t	title of certifier	and manner stated			29c. Licens	se number		29d. Date signe	ed (Month, Day, Year)
	20 1	30, Name and address of person who completed cause of death (Item 23a)					0.0.	.M.E.		June 12, 20	007
.0	A	na Rubio M	ID. Assista	nt Medical Exar	miner 1	11 Penn Stree	t, Baltim	ore, MD 2120	1		
State Registra	e ^{31. Da}	ate filed (Month	N 1 9 20	32 Registra	ar's Signatur	Spork	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 13 per fb 8868 6-25-07 vt State of Maryland Poepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month UNE Day 8, 2007 Physician 8:00A Oliver O. Amundsen /Medical 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center 4b. City, Town, or Location of Death 4c. County of Death Baltimore **Examiner** If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. (Marth, Pay 7/1925 Country linois 1 ☑ M 2 ☐ F 81 Director 347-14-4087 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Francisco. 10d. Inside City Limits 10c. City, Town or Location 1 ☐Yes 2☐No Director Maryland Baltimore Timonium 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21093 USA 12101 Tullamore Court Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married +₩Yes 2MNo Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Engineer Manufacture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Elizabeth Carlson Oscar Oliver Amundsen မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship *(Type. Print)* Ella V. Amundsen/Wife 12101 Tullamore Court, Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/20/2007 Timonium, MD 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD 21204 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CORONARY ARTERY DISEASE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of):
CONGESTIVE HEART FAILURE DAYS Examiner Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and is the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1☐ Yes 2**X** No 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ∏ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No I Director: A 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DØØ63974 KIENU

Si

Registrar JUN 1 9 200

30. Name and address of per

IMRAN SIDOIQI

31. Date filed (Month, Day, Year)

92. Registrar's Signature

son who completed cause of death (Item 23a) (Type, Print)

M. D.

7601 OSLER DRIVE

21204

TOWSON. MARYLAND

John David Adkins
07-04348 Pleas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

UNK UNK		1- For State	tate of Marylan		rtment of		nd Ment	al Hyg		eg. No.	20	U/	1504
Physicia	_	Registrar 1. Decedent's Name (First, Middle,Last)							2. Date of Death 3. Time			ime of Death	
Medical Examir	ner	John David Adk	ins						Month June 7, 20		Year		1133 hrs
		4a. Facility Name (if not instituti 418 North Milton Ave		per)	4	b. City, Town, o Baltimore	or Location o	f Death		4c.	. County of D	eath	
Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. la	ast birthday)	If Under 1 Ye			8. Date of Bi	th(MM/I	DD/YYYY) 9	. Birthpla oreign	ice (State or
Director		214-80-8032	1 X M 2 F	41	Yrs.	Months Da	ys Hours	Min.	larch	23,	1966	Country) MD
		Usual Residence of Decedent										140	
м япу		10a. State 10b. County			Town or Location	on							I. Inside City Limits
and f sho	5	MD n/a		Balt	imore				3				Yes 2 No
r death with the Maryland or items 23a or 28a-f show	Director	10e. Street and Number				10f. Zip Code			1	_	zen of What	Country?	
th the		n/a									USA		
th wit	era	11. Marital Status 1 Never Married 2	12. Was Deced			S Decedent of H es, specify Cuba)-	14. Race - A White, e		Indian, Black,
or dea	E		1 Yes	1 Yes 2 No			res 2 X No specify:			Sanatu			. .
rs afte	ò	15. Decedent's Education (Sp	or Dates:	completed)		's Usual Occup		ind of wor	k done		Specify: Kind of Busin	whi:	
2 hou "nati	ted	Elementary/Secondary (0-12				st of working li				1.02			4 1 1
hin 7 e. than	Be Completed	12	,	ŕ	Lands	caper				L	andsca	apin	g
5-0036 led within 7 Hygiene. other than		17. Father's Name (First, Middle	e, Last)				18.Mother	s Name (F	irst, Middle,	Maiden	Surname)		
215 be fill mtal H rked ent, t		Charles W. Adk	ins, Sr.				Julia	Luci	11e R	ober	ts		
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she marked other than "natural", or items 23a or 28a-f she marked other than "natural".	2	19a. Informant's Name/Relation				Address (Str							Code)
MD nd 2 sho alth and m 27 is		Cyndi Adkins/d 20a. Method of Disposition	aughter	1 20h	1850 T	renleig			KV111		Location - Ci		n State
or He frite		1 Burial 2 X Crematic	on 3 Removal from		crematory or oth		emetery,	·	Jate	200.	LOGARON OF	., 0, 10,	iii, otate
im Pag ment ment tant:		4 Donation 5 Other	Specify:		ro Crem	atory		6/13	3/07	Cat	onsvil	lle,	MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examine.		21. Signature Funeral Service Joseph K. 11ner	A I A	00	Le Le	ame and Addre	ss of Facility ineral	Home	of D	ulan	ey Val	lley	, Inc.
	- 111	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval											
Physician /Medical		failure. List only one cause on each line. Between Onset and Death											
Examiner		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.											
	ine.												
_ =	Examiner												
O, e be executed ysician and burial - transit		d.											
O, the ex sician	edical	X UNPENDED	A#E33E,27	,28a-f,	perME, G8	68 , 6/20/	/07 TT			177			
Box 68760 he death certificate by the attending physical bed for use as the bund	Ž	IF FEMALE: 23b. Was decedent pregnant in	the 23c. If yes, ou			tal death 3	Ectopic	pregnanc	cy	23	 d. Date of de Month 	livery Day	Year
x 6. th cert	Physician/M	past 12 months?		nt at time of de	oth =	ner (Specify)				1			
Box e death c the atten	hys	1 Yes 2 No 9 U	9 Olikilow		E-000E								
P.O. es that the igned by be detach	Š	Part II. Other significant cond	litions contributing to d	leath but not r	esulting in the u	nderlying cause	e given in Pa	irt I.	23e. Did	_			cause of death? y 4 Unknown
of Vital Records, ig Physician: The law requiremental three this certificate has been some and inector, page 2 should be	Completed								24a. Was				sy findings available pletion of cause of
eco ne law ne has	μŽ									ormed?	dea		2 No
m: Ti	ပိ	25. Was case referred to medic	cal			26.Pla	ce of Death	(Check on					
Vita ysicia ysicia direc	Ö.	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inc	patient 2	ER/Outpatient	3 DOA	Other ₄	Nursing	Home 5	Reside	ence 6 🗸	Other: So	ene
ision of Vital Battending Physician: rdeath. ector: After this certifi by the funeral director,		27. Manner of Death	28a. Date of (Month, D	Injury Day, Year)	28b. Time of I	′′	jury at Work		8d. Describe	how inj	ury occurred		
ion tendi for: /	atio		nding estigation 6/7/200	_	unk	1	Yes 2 X	No	unk				
Division tal or Attendi rs after death. al Director: /	ertification	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City											
	Cer	4 Homicide	(Opcomy)	House									pore, MD
Div To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)											
To the J within 2 To the J complet	Medical	29b. Signature and title of certi	and manner sta				nse number						
	-	O.C.M											,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
		30-Name and address of person who completed cause of death (Item 23a)											
			11/ B 01/ 11/ 11/ 11/ 11/ 11/ 11/ 11/ 11/ 11/										
		31. Date filed (Month, Day, Yea	32. egi	istrar's Signat		100					· -		
Regist	rar	./UN 1 9	/ / UU / // Zim	we h	7 Ace	451							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ep#s Name (First, Middle, Last) 2. Date of Death Month Year anchart Physician 2,40AM 07 /Medical Name (If not institution, give street and number) 4c. County of Death Examiner tation Extended Care TiMOTE If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 5/18/23 Birthplace (State or Foreign Country) **Funeral** Year) 84 Months Hours 215-14-7796 Director MD Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show 1 □Yes 2□No r 28a-f sh notified MD St Marys Charlotte Hall Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If the 27 is marked other than "natural", or items 23a or 3 any injury or other traumatic event, the Medical Examiner must be any injury or other traumatic event, the Medical Examiner must be any 29449 Charlotte Hall Road 20622 USA Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. MXYes 2 No Army If Yes, Give Year or Dates: WWI 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Shipping Longshoreman 17. Father's Name (First, Middle, Last) William Blaine Allen 18. Mother's Name (First, Middle, Maiden Surname) Be Catherine E. Seward ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Madeline Irene Allen / Daughter 1514 Jackson Street, Baltimore MD 21230 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Cedar Hill Cemetery 1 Burial 2 □ Cremation 3 □ Removal from State 06/22/2007 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 21. Signature of Funeral Service Licensee Victor P. Doda Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Dementia yKnown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ☐Yes 2☐No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 □ Yes 2[V] No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To within 24 hours after open... To the Funeral Director: After this 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No M 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 34359 (0410) 06/1

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

John S. Lah, m. D. 3900 Lock Raven Boulevard, Baltimore, Maryland 21218
31. Date filed (Month, Day, Year) 3. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Ernestine E. Ackerman 2007 /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner atonsville town timore Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/09/1917 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 🔀 F Director 215-18-9029 90 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show must be notifled at Baltimore Catonsville 1 ☐ Yes 217 No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane PV418 21228 United States ral", or Items 23a Examiner must b Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year, or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify. þ 3 X Widowed 4 ☐ Divorced 'natural", Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed within thealth and Mental Hygiene. Item 27 Is marked other than Line Assmbly Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Ella M. Hook Ernest Hovis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Kenneth Woodzelle (Son) 4002 Harrison Road, Beltsville, Maryland 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 06/18/2007 4 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland of Funeral Service Licensee 21. Signature 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final thero Physician Sclevo sease resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and I-transit Due to (or as a consequence of): burial-Box 68760, the attending physician hed for use as the buria certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) P.O. | detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ should be 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has be a s autopsy performe page certificate 2 A Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 N ۵ 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Certification: or Attending (Month, Day Year) Injury 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director: A completely filled in by the f death. 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital 🗠 CertifyIng PhysIcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 711 Maid hoice Lane 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 9 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 200 Bo **Physician** ea June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ruare 405 If Under 1 Year If Under 24 8. Date of Birth (Month, Day, Year) 7. Age In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 212-76-2659 Days Min 1 M 2 □ F Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 28a-f show notified at Rose 1 ☐ Yes 2 ☑ No MD **Funeral Director** Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or idical Examiner must be SA 21237 Libra Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Amony can Be Completed by Baltimore, Maryland 21215-003 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturany injury or other traumatic event, the Medicall once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Mag 918 Mars ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosedale niece MD ovallen 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐Removal from State 107 Baltimore 4 Donation 5 Other (Specify) 1, ew 6 21. Signature of Funeral Servi Licensee 22. Name and Address Hans 5126 MO 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** erKalemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician a Division or Vital Records, P.O. Box 68760 Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has be irector, page 2 s autopsy performed? yes 2 No 1☐ Yes this certific al director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of contifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Schra 0 er Registrar's Signature 31. Date filed (Month, Day, 32 State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2:00A 14 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Forest Hill 1318 Grandview Ct. 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours 1**X** M 2□ F 8 3/rs. 202-12-1511 1923 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at Forest Hill Harford MD 1 ☐ Yes 2 No Director 10f. Zip Code 21047 10g. Citizen of What Country? 10e. Street and Number 1318 Grandview Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: **Army** 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 🌠 No Specify: Baltimore, Maryland 21215-0036 Specify: White λq 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Military Army N/A 12 Mother's Name (First, Middle, Maiden Surname)
 Filomena Rosalti 17. Father's Name (First Middle, Guistino Baca Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1318 Grandview Ct. Forest Hill, MD 21047 19a. Informant's Name/Relationship (Type. Print) Elsie Baca- Spouse 20b. Place of Disposition (Name of cemetery, crematory or other of 20c. Location - City or Town, State 20a. Method of Disposition Evans Funeral Chapel 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/19/07 Forest Hill, MD 22. Name and Add s Queijo Port Dr. Forest Hill, MO 21. Signature of Funeral Service License Evans Fuleral Chapol Belair Kimberly 21050 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disea shock, or heart failur Immediate Cause (Final / disease or condition resulting in death) Cardiac Asystole **Physician** /Medical Due to (or as a consequence of) failure Examiner Congestive Heart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to for as a runsequence of Examiner 6 months ig physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Renal for Lyre Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) ned by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Coronary Astery Distale page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an Bardio renal autopsy performed? Yes 2 No 1□ Yes director. Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No. Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) n 24 hours after des ne Funeral Directo pletely filled in by th 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor **To the Fune** completely fi 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier (10

2 State

State Registrar 31. Date filed (Month, Day, Year) 82. Registrar's S

B. PAREKH MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D0018424

FALLSTON MD-21047

June-18-2007

CLARA BUTT

				Please				idelible Ink. artment of F			Are Legible.		
		1	For State Registrar		Olale of	iviai yiai		ertificate of			Reg. No. 2	7 19647	
Physic	ciar		Decedent's Name		_					2. Date of De Month	Day Year		
/Med	lica	1	Clara 4a. Facility Name (h					4b. City, Town, o	r Location of De	June	12, 200 4c. County of Dea		
Exam	ine			lla Maris		. ,		Ti	monium			imore	
Funera			5. Social Security N	lumber 6. 5			last birthday Yrs.	If Under 1 Year Months Days		lin. (Month, Da	(y, Year)	rthplace (State or Foreign country)	
Directo	r	-	214-24-00 Usual Residence of			84				March 2	25,1925	Maryland	
aryland show	١,		10a. State	10b. County		10c. Ci	ty, Town or L					10d. Inside City Limits 1 ☐ Yes 2X No	
the Mi 28a-f	4000	3	Maryland 10e. Street and Nur		timore			Perry Ha.		T	10g. Citizen of What C		
h with 23a or st be	100	<u>8</u>	4701 For	ge Road				21	128		U. S.	Α.	
er deat tems	1000		11. Marital Status		12. Was Deced Armed Forc	es?	J.S. 13	. Was Decedent of H If Yes, specify Cub	lisp <i>a</i> nic Origin? an, Mexican, Pu	(Specify Yes or No uerto Rican, etc.)	14. Race - American Indian, Black, White, etc.		
Ir; or t	1	2	1 ☐ Never Marr 3 🛣 Widowed	ried 2 Mamied 4 Divorced	1 ☐ Yes 2 If Yes, Give Year or Date			1 ☐ Yes 2X No	Specify:		Specify:	White	
72 hou	3	ופח	(Spec	15. Decedent's E	ducation ade completed)		i (Giv	edent's Usual Occup e kind of work done	during most of	working	16b. Kind of Busines	s/Industry	
within sne.		Collibrated	Elementary/Seco		College (1-4	or 5+)		DO NOT use retire ircraft T	-/	an	Aerospace	Defense	
Hygie other ent, th	6		17. Father's Name	(First, Middle, Las	t)		A	IICIAIC I			, Maiden Surname)		
Vidio	100	2	George K	ahl, Jr.					Barb	ara Leist	ner		
VICINO 12 sho h and 7 Is me traume		1	19a. Informant's Na	•			1	•			per, City or Town, State,		
s 1 and f Healf ftem 2	1	1	Mrs. Joan 20a. Method of Disp	position		20b.	Place of Disc	oosition (Name of ematory or other pla	1	Date Date	ood, Maryla 20c. Location - City o		
mit. Pages partment of portant: If It				☐ Cremation 3 [5 ☐ Other (Speci		ate	. Jose	ph Church	Cem 06/	18/2007	Baltimore,	Maryland	
perill in the wind yield a Landon permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any fijury or other traumatic event, the Medical Examiner must be notified at	Ource.		21. Signature of Fu	uneral Service Lice	ensee	· Do		22. Name and Addre	ess of Facility S ir Road	chimunek . Baltimo	Funeral Ho ore, Maryla	me Inc. nd 21236	
15000		1	23a. Part1. Enter t	the disease, or con art failure. List only	nplications that car	used the dea		nter the mode of dyi				Approximate Interval Between	
Physician	_		Immediate Cause disease or condition resulting in death)	on				ACCIDENT				Onset and Death	
/Medica Examine	-	1	rosum g m sourry		Due to (o	r as a conse	quence of):						
D #		2	Sequentially list co if any, leading to in	nditions, nmediate	Due to (o	r as a conse	quence of):						
executed executed in and ial-transit		Cyalliller	Cause (Disease or that initiated events resulting in death)	S	c	r as a conse	guence of):						
wrequires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	- 1-	-11		•	d								
. DOX 00/01 death certificate be e attending physicia id for use as the bur		rnysician/imeuica	IF FEMALE:						27	186 0			
DOX sath cer attendin for use		lan	23b. Was deceden	2 months?		ome pf pregr th 2□Fet nt at time of	tal death 3	□Ectopic pregnanc	гу		23d. Date of d Month	elivery Day Year	
the de		nysic	1 ☐ Yes 2] 9 ☐ Unknown		9☐ Unknov		douti o						
requires that the een signed by the		D.	Part II. Other signi	ficant conditions	contributing to dea	th but not re	sulting in the	underlying cause gi	ven in Part I.		tobacco use contribute		
ecords law requires as been sign 2 should be											Yes 2 No 3 □		
he law e has b		Сотрыете								— 24a. Was auto perf	opsy prior to orm <u>e</u> d? death'	autopsy findings available o completion of cause of	
VILCII Ician: T Sertificati ector, pa		De C	25. Was case refe	rred to medical				·	26. Place of	1 Yes Death (Check only		es 2 No	
Or V Physic rthis ce		0	examiner?					SIN OLI DOA			idence 6 X Other (Sp	pecify) HOSPICE	
SION C tending P leath. tor: After the funera		E C	27. Manner of Dear	ith 5 □ Pending investigatio		, Day Year)	28b. Time Injury	Wo	ıryat ırk?]Yes 2⊡No	28d. Describe	how injury occurred		
Attention death ector:	9	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not I	be 28e. Place of	of injury - At I g, etc. (Spec		treet, factory, office			(Street and Number or own, State)	Rural Route Number,	
ultal or ral Dir lled in													
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	-	Medical	29a. Certifier (Check only one)			sis of examin					e cause(s) and manner , date and place, and d		
To the within To the compl	1	Me	29b. Signature and	d (itle of certifier)				se number		29d. Date signed (Mo	nth, Day, Year)	
. 1	/		>	/					372		6/12	-/07	
15	7		30. Name and add						ΨΤΜΛΙΙΤ Ι	IN MOSTO	no		
	Stat	е	31. Date filed (Mor	RIQ MAHMO nth, Day, Year)	32 A e	gistrar's Sign	nature	LEY RD.	TIMUNII	UM, MD210	7.3		
Regis	_			JUN 1 9 2	2007 1	ر سعدی	K A						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2007 **Physician** June 15, 12:12 A M Barbara Jane Bach /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Gilchrist | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 02-17-1934 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 □ M 2 X F 172-26-2480 Director 73 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County of Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Jashasa (Sach June 15,200) altimore, Maryland 21215-0036 12:124 Director Maryland Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21015 U.S.A. 509 Adelaide Lane Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritai Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify Specify: Completed by 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Smith Charles Hemmerle ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 509 Adelaide Lane Bel Air, MD 21015 Tillman H. Bach (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Bayview Crematory Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 06-19-2007 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Light 1.la Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CAncel eR month **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown strokes 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 5 Pending investigation 1 Natural in 24 hours are:
the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 15, 2007 30. Name and address of person who completed caused death (Item 23a) (Type, Print) N. Charles St. Balto. Md Z: 205 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

07-04478
Evette Bridges

vette Bridges		State of Maryland / Department of Health		/gierie	200	7 1954
	Re	For State Certificate of Death		Reg. N 2. Date of Death		3. Time of Death
Physician/	L	Decedent's Name (First, Middle, Last)		Month Day June 11, 200	v Year	1753 hrs
Medical Examiner		EVETTE Bridges	own, or Location of Death		4c. County of Detath	
	48	a. Facility Name (if not institution, give street and number) 4b. City, To Johns Hopkins Hospital Baltim			NIA	
	5	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Unde		. 8. Date of Birth (M	M/DD/YYYY) 9. Birth	nplace (State or
Funeral Director		Months		11.10 21	Foreign 101つ Cou	n intry) (1)
Director	0	19-80-9201 1 M 2 XF 43 Yrs.		Mug. ou,	1765	NIA.
in a sec property in	_	sual Residence of Decedent Oa, State 10b. County / 10c. City, Town or Location				10d. Inside City Limits
ž "l		Md N/A Rationer	`0			1 Yes 2 No
ylanc s-f sh	-	0e, Street and Number 10f. Zip	Code	10g. (Citizen of What Coun	itry?
the Maryland a or 28a-f show	1	FOI Ma Fldare, C+#102 3	1202		115	A
_ ⇒ ≂		1. Marital Status 12. Was Decedent Ever in U.S. 13. Was Deceden	nt of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Americ	can Indian, Black,
r death with or items 23 must be no	'	Married 2 Married Armed Forces? If Yes, specific	y Cuban, Mexican, Puerto	Rican, etc.)	. White, etc.	
		1 Yes 2 No 1 Yes 2 No 1 Yes 2	No specify:		Specify: P	ack
ural' Dy	\vdash	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual (Occupation (Give kind of v		b. Kind of Business/li	ndustry
2 hours "natur	\vdash	Elementary/Secondary (0-12) College (1-4 or 5+)	king life. DO NOT use reti	red)	0 . /	/
136 thin 7 than than edica		11 O Nur.	se		Private	Duty
5-0036 ed within 72 hour lygiene. to ther than "nature Medical Exant Completed	1	7. Father's Name (First, Middle, Last)	18.Mother's Name	e (First, Middle, Maio	len Surname)	
21215-0036 Jold be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner. To Be Completed by 1		Eugene Allen	JACGL		Spe	nce
		9a. Inform It's Name/Relationship (Type, rint) (Husband, 19b. Mailing Address	(Street and Numb or	Rural Route Number	, City or Tow , State	, Zip Code)
, MD 2 and 2 shou tealth and 1 tem 27 is 1 traumatic		Mr. James Bridges 1917 Bu	irnW.00A	Ka. Ba	C. Location - City or	Town State
ore, MEss 1 and 2 s of Health at If item 27	2	20a. Method of Disposition 20b. Place of Disposition (Nan crematory or other place) Removal from State	/	/	i i	Town, State
MOF6 Pages 1 ent of F	1	4 Donation 5 Other Specify: Mt. Zioo	6/0	22/2007 1	ansdou	une, Ma.
Baltimore, permit. Pages 1 a Department of He Important: If ite	2	21 Signature of Funeral Service Licensee 22. Name and	Address of Facility	Funeral 1	Homa PA	
1. E 2 E W		Willoh L. KUM 125250	V. NOTHS AV	e. Balto.	Md 2121	6
Physician	2	23d Part I. Enter the disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line.	of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
Medical Examiner	9	Immediate Cause (Final disease a. Narcotic intoxication				Death
-Xaiiiiiei	1	or condition resulting in death) Due to (or as a consequence of):				
		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
ted Insit Fxaminer		causis. Enter Underlying Cause				
=		(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
and trans	-	d	 			
60, ate be executed hysician and e burial - transit	3	X unpended AMEASE, 27, 28a-f, perME, g869, 7	² /25/07 TT			
760, icate be physicate burn the burn t		IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth	3 Ectopic pregr	nancy	23d. Date of deliver Month	y Day Year
ox 687(auth certifica attending pl for use as th	١	past 12 months? 1 Live birth 2 Fetal death 5 Other (Spe		idiloy		
Sox death le atte		1 Yes 2 No 9 V Unknown g Unknown				
D. B. It the de by the ached f		Part II. Other significant conditions contributing to death but not resulting in the underlying	g cause given in Part I.	l .		the cause of death?
P.C				1 Yes	2 No 3 Pro	bably 4 🗸 Unknown
Records, The law requires ficate has been signage 2 should be		-		24a, Was an autopsy		utopsy findings available completion of cause of
COC Law Law has been	5		··	performe		
The		25. Was case referred to medical	26.Place of Death (Check		INO I	<u> </u>
ital iician s cert irecto	۱۵	examiner? Hospital: Inpatient 2 FR/Outpatient 3 I	Othor		esidence 6 Othe	er:
Physical dispersional dispersio		27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe hov	w injury occurred	
on of or or or or or or or or or or or or or	5	1 Natural 5	1 Yes 2 X No	unk		
ivision I or Attend after death. Director:	<u> </u>	2 Accident Investigation 0/11/2007 CIRC 28e Place of Injury - At home, farm, street, factor	y, office building, etc.	28f. Location (Str		ural Route Number, City
Division of Vital Records, P.O. Box 687 Is an artending Physician: The law requires that the death certifical and price death. The Director: After this certificate has been signed by the attending pled in by the funeral director, page 2 should be detached for use as the definition of To Bo Completed by Physician Individual Completed by Physician Individual Completed by Physician Individual Completed by Physician Individual Completed by Physician Individual Completed by Physician Individual Completed by Physician Individual Completed by Physician Individual Completed by Physician Individual Completed by Physician Individual Completed by Physician Individual Completed by Physician Individual Completed by Physician Individual Completed by Completed By	Certification	Suicide of A Could not be determined (Specify) Tohng Hopking Hogpity		600 N. Wol	fe St. Balti	more, MD
Di 24 hours : e Funeral etely filled	<u>"</u>	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at th	e time, date and place, ar	nd due to the cause(s) and manner as sta	ited.
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitional Certification: To Be Completed by Physician Medical Expedical	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in m	ny opinion, death occurred	at the time, date an	d place, and due to t	he cause(s)
To To To To	Ě	29b. Signature and title of certifier 25b.	c. License number	12	29d. Date signed (M	onth, Day, Year)
		T/ 11/2	O.C.M.E.		June 12, 2007	
	-	30. Name and address of person who completed cause of death (Item 23a)				
-0		Theodore M. King, Jr., MD. Assistant Medical Examiner 111 P	enn Street, Baltimo	ore, MD 21201		
Stat	te.	31. Date filed (Month, Day, Year) 32 Registrar's Signature				
Registra	~	1111 1 9 2007 May & Spelet				
DHMH 17 Rev 1/200)1	ORIGINAL				

3. Time of Death

2. Date of Death

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Physician	-	Lola May Brinkmeye		June 1.	3,_20	007	7:30	ам			
/Medica Examine	•	4a. Facility Name (If not institution, give stre			4b. City, Town, or	Location of Death		4c. County of Death			
	ı	Mariner Heath Care				en Burnie			Anne Ar		
Funeral		5. Social Security Number 6. Sex	-Y-	7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours			8. Date of Birth (Month, Day	Year)	9. Birthpl Coun	ace (State or	Foreign
Director	-	213-03-7460		90 Yrs.			Oct. 1.	3, 19	16 Mar	y1and	
and will	+	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10	0d. Inside Cit	y Limits
danyi	6	MD N/A		Ba	altimore			1 XYes 2 □ No			
28a	Director	10e. Street and Number			10f. Zip Code			10g. Citize	on of What Coun	try?	
3a or	5	2607 Dulany Str	eet			21223		Ur	nited St	ates	
death	Funeral		Was Decedent Ev Armed Forces?	ver in U.S. 13	. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp	ecify Yes or No-	14	Race - America		
or its	=	Never Married 2 ☐ Married	1 ☐ Yes 2 ☐ No	o	1 ☐ Yes X☐ No	Specify:		S		nite	
irel',	g g	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:								
72 h	ete	15. Decedent's Educat (Specify only highest grade c	ion ompleted)	(Giv	edent's Usual Occup e kind of work done DO NOT use retired	during most of work	ing	16b. Kind	f of Business/Inc	dustry	
within	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)	Punch Or			Moreov I			
Hygie ther int.		17. Father's Name (First, Middle, Last)		Rey	runcii o <u>t</u>	18. Mother's Nam	e (First, Middle,		Mercy Hospital		
od be	lo Be	Charles Henry Brin	ıkmever			Elise	Clark				
Shoul mark	=	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip								Code)	
ulth ar		Nancy Turrini - Ni	iece	208	3 Washburr	a Avenue,	Brookly	n, M	21225		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event. I'm Marylan Evanting must be notified at any injury or other traumatic event. I'm Marylan Evanting must be notified at any injury or other traumatic event. I'm Marylan Evanting must be notified at any injury or other traumatic event.		20a. Method of Disposition		20b. Place of Disp	oosition (Name of		Date	20c. Loca	ation - City or To	wn, State	
Page Bent o nnt: If ry or		Burial 2 ☐ Cremation 3 ☐ Ren Donation 5 ☐ Other (Specify)	noval from State		ematory or other place Park	1 0-14	4-2007	Wood	dlawn, N	MD	
partm ports y inju	1	21 Strature of Funeral Service Licenses	MA	and a	22. Name and Addre	ss of Facility Am	rose Fu	inera.	I Home,	Inc.	
8858		(Jennier)	KXX-	2/1	2719 Hammo				ne, MD 2	21227	
		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	cause on each line	θ.				rest,		Approximate Interval Bety Onset and D	ween
Physician		Immediate Cause (Final disease or condition		erebro	vos cular	Accid	ent			3 week	
/Medical Examiner		resulting in death)		consequence of):							
		Sequentially list conditions, b.	Post de Course a	aniatining and M.							
be is	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (ur as a	i done aquerice of):							
and I-tran	Xar	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):							
death certificate be executed e attending physicien and id for use as the burial-transit	siclan/Medical	0. ,									
nding use a	Ž	IF FEMALE: 23b. Was decedent pregnant	. If yes, outcome o		. C.			23	3d. Date of delive		
000	Ca	in the past 12 months? 1 ☐ Yes 2 ☒ No	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown		□Ectopic pregnanc □ Other (specify) _	у			Month	Day 1	Year
by th	Phys	9 Unknown	9LI Unknown				-				
gned be de	by B	Part II. Other significant conditions contri	ibuting to death bu	it not resulting in the	underlying cause gr	ven in Part I.			e contribute to th		Jaknowa
equir en si ould	Completed	ruggentahan						Yes 2□	lNo 3∏Prob	ably + pac	
law r as be	ple.						24a. Was autop	osy		psy findings mpletion of c	available ause of
The page	S						1 ☐ Yes	rmed?	death?	2158 No	
ertific sctor,	Be	25. Was case referred to medical examiner?			. 04	26. Place of Dea					
hysi this c	မ	1 Tes 2DENO	spital: 1 Inpatier		ent 3 DOA		ome 5 Resident			y)	
To the Hospital or Attending Physicien: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detected.	Certification:	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day	y 28b. Time 'Year) Injury	/ Wo	rk?]Yes 2 □No	200. Describe i	now injury	occurred		
deatl deatl ctor: y the	lcai	3 Suicide 6 Could not be	28e. Place of Inju	ıry - At home, farm,	street, factory, office				Number or Rura	al Route Num	iber,
after after Dire	erti	4 Homicide	building, etc				City or To	wn, State)			
spita nours neral		29a. Certifier 1 \(\sum_{\text{A}} \) Certifying Physic	cian: To the best of	of my knowledge, de	ath occurred at the t	me, date and place	, and due to the	cause(s) a	and manner as s	tated.	
24 to Fu	Medical	(Check only 2 Medical Examine one)	er: On the basis of and manner sta	examination and/or ted.	investigation, in my	opinion, death occu	rred at the time,	date and p	Slace, and due to	o the cause(s	i)
To the within To the Comp	Ž	29b. Signature and title of certifier	. ^			se number			signed (Month,		
1		Mochen	of Mon		D-	40251		6/1	L3/07		
		30. Name and address of person who com	pleted cause of de	eath (Item 23a) (Typ	e, Print) 325	40521 HOSPITAL BURME,	DRIVE	Sw	T€ 20	8	
11/		DL. OCHANEY			STEH	(SURME,	MD 2	1091			

Registrar

JUN 1 4 2997

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Day **Physician** 11:40P M 06-13-2007 Elaine May Brass /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Burnie Glen Burnie Health and Rehabilitation Anne Arundel Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 ☐ M 2 🔀 213-18-1987 86 10-20-1920 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Director Anne Arundel Linthicum MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21090 U.S.A. 705 Juniper Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☒ No Be Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert H. Sharp, Sr. Clara Swann ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 705 Juniper Road; Linthicum, MD 21090 Mr. Robert Sharp / brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 □ Cremation 3 □ Removal from State 06-25-2007 Baltimore, MD Moreland Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home, PA 21. Signature of Funeral Service Licensee 1 Second Ave SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ALZHEIMER Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner ending physician and use as the burial-tran-Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the a 1 ☐ Yes 2 12 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No page, 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Hospital: 1 Yes 2 No 1 Inpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ☐ ER/Outpatient Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

Baltimore, Maryland 21215-0036

m State

Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of

29a. Certifier

KIS DHARMASENA, M.D. 32. Registrar's Signature

Amola, mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D17753

POTRESH. BALTIMONE

29d. Date signed (Month, Day, Year)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 245 AM Leona E. Bragg JUNE 16 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL n/a SAINT AGNES BALTINGURE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec 13, 1915 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1□M 2 F 214-46-9497 91 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No n/a Maryland Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3704 Coolidge Avenue 21229 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s any injury or other traumatic event, the Medical Examiner must any injury or other traumatic event, the Medical Examiner must ones. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White \$ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Schull Martha E. Fishpaugh ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Huntemann / Granddaughter 21193 Vineland Square, Ashburn, Virginia 20147 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Meadowridge Mem. Park: 6/21/2007 | Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Sonature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PULMONARY 4 EARS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, signed by the attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 2 No or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After (Month, Day Year) Injury 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

the

10

State

Registrar

ERIL JOSU, MP P21617

29c. License number

AVENUE, BALTIMURE

29d. Date signed (Month, Day, Year)

MD

2007

MUD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

> 900 CATON

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Nancy A. Bilek 6:10 pM 2007 June 12 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Center Towson if Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 □ M 2 🖫 F August 18,1930 Maryland Director 217 26 4295 76 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Baltimore Maryland Anne Arundel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5707 Gischel Street 21225 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher School School year or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Joseph Vokroy Marie Hranicka ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra J. Michael Bilek / son Wilton P.O. Box 27 Wye Mills, Maryland 21679 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery 6/16/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrovascular Acciden Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examine burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical ass attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28b. Time of 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

State Registrar

Conthia Smars MD

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0005137

SUCIANUMD 6701 N. CHANLES St. Baltimure MD 21204

31. Date filed (Month, Day, Year)

32 Registrar's Signature

JUN 1 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 6 CLAYTON **Physician** SONNY HORACE 08:00 PM 2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE VA REMABILITATION - Extended CARE NIA BALTIMOR e If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Sex 10 M 2□ F Days Months Hours 214-22-7444 Director June 27 1929 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Medical Examiner must be notified at 1 PYes 2 No Director Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Wood Aug 1904. 403 or items 23a Vellow 21209 4800 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ ✔ 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or item any injury or other traumatic event, the Mental once. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 2 3 ☐ Widowed 4 ☑ ĐIVorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8.th Baker Foco 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be rslive Clayton Manie 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 W. 189 th Street APTHE lamon daughter New: Cr. No 10040 20c. Location - City or Trwn, State lay 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Balto, mD 4 □Donation 5 Other (Specify)
21. Signature Funer Service Lic Crematory 6-23-07 letro 22. Name and Address Facility AM 1030 Midrelley Dr. Jessup, PA 18434 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, 9 heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final Physician Metatatic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 → No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 → No 1 Yes the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of ___th Check only one examiner' Other: 4 Hursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Yes 2 No this 27. Manner Leath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 atural 5 Pending death. 1 Tes 2 No 2 Accident investigation Director; 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the lime, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 247804 nomice 2+1 Surveyed and address of person who completed cause of death (Item 23a) (Type, Print) 3900 Loch Raven Baltimore 10 Mrowiec 31. Date filed (Month, Day, Year)-32. Rigistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUN 1 9 2007

07-04525 Sterling Carr	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Seedle 19	1- For State Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death
Physician/ Medical Examiner	Sterling Carr June 13, 2007 Year 0022 hrs
	4a. Facility Name (if not institution, give street and number) University Hospital 4b. City, Town, or Location of Death Baltimore 4c. County of Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 15. Months Days Hours Min. 7. Age (In yrs. last birthday) 15. Months Days Hours Min. 7. Age (In yrs. last birthday) 16. Sex 17. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 18. Days Hours Min. 19. Birth(MM/DD/YYYY) 19. Birthplace (State or Foreign Country) 19. Country
id how any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No
ith the Maryland 23a or 28a-f show notified at once. al Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Menial Hygiene. Titem 27 is marked other than "natural", or items 23a or 28a-f short ranumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marjtäl Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Specify:
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death wiment of Health and Mental Hygiene. Innt: If item 27 is marked other than "natural", or items or other transmatic event, the Medical Examiner must be To Be Completed by Funera	or Dates: 15. Decedent's Education (Specific only kindert grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry
215-0036 be filed within 72 hour ntal Hygiene. ked other than "matuent, the Medical Exar	
D 2121 should be fill mid Mental I is marked attic event, I To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Travenia Anthony - France 4909 Challean Rd. Apt. B-7 Bacto. nd., 21207
0	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 20c. Location - City or Town, State
Baltimore, permit. Pages I an Department of He Important: If ite injury or other tr	4 Donation/5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 270 Fred thickon Pass Care P. march Funeral Home Bulto and 21229
Physician Medical	23a Pan X Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
Examiner	or condition resulting in death) Due to (or as a consequence of):
it Xaminer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated c.
	events resulting in death) Last Due to (or as a consequence of): d.
58760,	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
Box 68760, death certificate be the attending physical for use as the bunsician/Mee	1 Yes 2 No 9 Unknown 1 Unknown 1 Unknown 2 Unk
ires that the designed by the Ibe detached for the Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
cords aw requ as been 2 should	24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
tal R cian: T certifica ector, pa	25. Was case referred to medical 20. Flace of Death (Check Only Only)
of Vir	1 Ves 2 No 1 I inpatient 2 Exocupation 3 Box 4 Italianing from 5 Italianing from 5 Italianing from 6 I
Division of Vital Rec Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	
To the He within 24 within 24 completel	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

his, my J 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD

29b. Signature and title of certifier

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) June 13, 2007

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State 31. Date filed (Month, Pay, Year) 2007

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3136 AM 2007 ictoria Conningham 11. 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death St. Agnes Baltmor Hospita If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Days Hours 1 M 2 K F 218-46-8705 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 □ No Baltimore NA MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Hvenue IJSA 1228 Druic Hill14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) onvalescen ss islant Homes 12 Nursing 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ViolaVictoria Treene ero unningham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
+026 Walrad Street MD 21229 19a. Informant's Name/Relationship (Type. Print) Cunning ham Viola (mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 □Removal from State Cemeter Baltimore 25/01 4 Donation 5 ☐ Other (Specify) 61 22. Name and Address of Facility

50 Seph L. Russ
222 W. North Z.M. Baltimore, MD 21216 Larres Approximate Interval Between Onset and Death rald LESOSCI Due to (or as a consequence of) Late to (or as a nonsequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 9□Unknown Day 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 2 XN 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? Year 1 Natural

The law requires that the death certificate be executed or Vital Records, F.O. Box 68760, Hospital or Attending Physician: Division

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or itel

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

nt of Health and Mental Hygiene.

If Item 27 is marked other than "natural", or other traumatic event, the Medical Exa. 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or conce. 21. Signature of Funeral Service Ligenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed After this certificate director. 25. Was case referred to medical examiner? Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral of 27. Manper of Death 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certified 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Da Day, Year) Registrar's Signature State

Registrar DHMH 17 Rev 1/2001 9 2007

		1 = For State Registrar			Ce	ertificate of	Death		Reg. No.		
Physicia /Medic		1. Decedent's Name (First, Middle, La	St)	•	Car			2. Date of De Month June 14	Day	O7	3. Time of Death 1:30 P
Examin		4a. Facility Name (If not institution, giv				4b. City, Town, o	or Location of Death			County of Death	
	H	5019 Tartan Hill 5. Social Security Number 6. S		/la vec	la et hirthela.	Perry H		9 Date of Bir		altimor	elece (State or Foreig
Funeral Director			M 2□F	56	last birthday Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da	y, Year)	West	Virginia
yland yland		10a. State 10b. County		10c. City	y, Town or l	_ocation					10d. Inside City Limit
death with the Maryland ms 23a or 28a-f show	tor	Maryland Baltimo	re	Per	ry Ha	11					1 ☐ Yes 2 <u>X</u> N
ith the	Dire	10e. Street and Number				10f. Zip Code				en of What Cou	ntry?
ath w	rail	5019 Tartan Hill				21128			U.S.		4
al', or ite	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 X N ff Yes, Give Year or Dates:	ever in U.	S. 13	. Was Decedent of H If Yes, specify Cub	tispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		4. Race - Ameri Black, White, Specify:Whit	etc.
72 h	etec	15. Decedent's E (Specify only highest gro	ducation ade completed)		16a. Dec	edent's Usual Occup e kind of work done	oation during most of worki d)	ng	16b. Kin	d of Business/In	dustry
2 should be filed within 72 ho and Mental Hygiene. is marked othar than "natur raumatic avent, tra Mudical	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)			1 Manager			n Cork 8	& Seal
ital Hyg	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		, Maiden S	Sumame)	
d 2 should be filed th and Mental Hyg ?? is marked othe traumatic avent,	ို	Leonard Carr	Time Print)		10h Mai	ling Address /Street	June Wag		er City or	Town State Zin	Code)
-5 - 5		19a. Informant's Name/Relationship (Type, Print) Christine Carr (Wife) 19b. Mailing Address (Street and Number or It 5019 Tartan Hill Rd							L1, M	D 21128	
permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other 1 once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special Control of Contr		_ a	emetery, cr	position (Name of ematory or other pla Cemetery	ce)	-2007 1		more, M	
artme ortan injur	1	21. Signature of Funeral Service Lice		Vai			ess of Facility Sch				
Depar Impo		Difamo	Rine	Re			r Rd Balt				IIIC.
Medical Examiner bhysician and sthe burial-transit	edical Examiner	Sequentially list conditions, any leading to minibility cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or as a d	a consaçı	uence of):		ma in				
To the hospital or Attending Prysicien: The taw requires that the death certific the hors after death. Within 24 hours after death. Within 25 hours after death. Within 25 hours after death. After this certificate has been signed by the attending by completely filled in by the funeral director, page 2 should be detached for use as it.	Physician/Me	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknow							23d. Date of delivery Month Day Ye		
signed by	þ	Part II. Other significant conditions continuiting to death but not resulting in the underlying cause given in Part I.							Did tobacco use contribute to the cause of death		
e has bee age 2 shor	Completed			• · ·				24a. Was auto perfo 1 \sum Yes	psy ormed?	24b. Were auto prior to co death? 1 \sum Yes	opsy findings availab impletion of cause of
ien: rtifica stor, p	0	25. Was case referred to medical					26. Place of Death				
hysic his ce I direc	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie	nt 2 🗆	ER/Outpati	BIIL 3 DOA	ner: 4 🗆 Nursing Ho	me 5 PResi	dence 6	□Other (Speci	fy)
auth. sath. or: After th		27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident Investigation		ry v Year)	28b. Time Injury	Wo	ry at rk?]Yes 2 ☐ No	28d. Describe	how injury	occurred	
s after de	Certification;	3 Suicide 6 Could not to determined	28e. Place of frig building, etc	ury - At ho c. (Specify	ome, farm, s	street, factory, office			Street and wn, State)		al Route Number,
24 hour	edicai (nysician: To the best of miner: On the basis of and manner sta	examina							
To th comp	Me	29b. Signature and litle of certifier	ac.	2		29c. Licen:	12979			signed (Month,	Day, Year) 2007 21231
()		30. Name and address of person who Michael A. Ca 31. Date filed (Month) Pay Year)	completed cause of d	eath (Item	n 23a) (Typo	e, Print)	Pardela		11.	~ M	2/23/
8		Michael A. Ca	raucci, N	7. ().	40	100/14	Droggwa	y. 13°	7 (77)	Was C List	1251

DHMH 17 Rev 1/2001

			1 - State Registrar			Certificate of	Death	,	Reg. No.	JU!	19000
15	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Month Day Year		
	/Medic		Dr. Benjamin S.					JU			10:25 M
	Examir	ner	4a. Facility Name (If not institution, give s Saint Joseph h				TOWS	on	4c. Cou		imore
	Funeral Director		030-09-001/	M 2□ F 7. Age (In	yrs. last birth	nday) If Under 1 Year Months Days		8. Date of Bir (Month, Da April	ay, Year)		lace (State or Foreign try) W York
	land bw		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town	or Location				1	0d. Inside City Limits
	Mary -f sho	to	 Maryland Baltimo	re	Time	onium					1 ☐ Yes 2 🛣 No
	nr 28a nr 28a	irec	10e. Street and Number	10	1 ±1111	10f. Zip Code			10g. Citizen	of What Coun	try?
	th wit 23a o 1st be	Funeral Directo	2212 Forest Ridge	Road		21 09	3			USA	
	r dea	nel	THE THE TAX STATES	2. Was Decedent Ever Armed Forces?	in U.S.	13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No Rican, etc.))- 14. F	Race - Americ Black, White,	
2000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1⊡Yes 2 X No					white
5	"natu	Completed	15. Decedent's Educ (Specify only highest grade	eation completed)	16a. l	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of work	ring	16b. Kind of	f Business/Ind	fustry
7	withir ene. than he Me	m C	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		Dentist	na)		 Medi	cal	
ע כ	filed Hygi other ent, ti	ပ္	17. Father's Name (First, Middle, Last)			DETTEL	18. Mother's Nam	e (First, Middle			
0	lld be lental rked c	To Be	Benjamin S. Crosb	y, Sr.			Beatr	ice Bla	ckburn		
<u> </u>	shou and N s mar	-	19a. Informant's Name/Relationship (Typ	pe. Print)	19b.	Mailing Address (Street				vn, State, Zip	Code)
2	and 2 salth a n 27 ii		Paul Crosby (son)			01 Green Ac		Floren	ce, SC	2950	D5
ב ב	of He		20a. Method of Disposition 1 Burial 2 Cremation 3 Re	emoval from State	Ob. Place of cemeters	Disposition (Name of v, crematory or other pla	ice)	Date	20c. Locatio	n - City or To	wn, State
	. Pag tment tant: jury o	1	4 □ Donation 5 □ Other (Specify)	Sinova, nom Glato	Hillto	p Svc. Corp		<u> - 2007</u>	Towsc	n, Mar	yland
חמו	permit Depar Impor any in		21. Signature of Funeral Service License	ee		22. Name and Address 1050 York					Home, Inc.
	7 25		23a. 1 art1. En er the disease, or compli- shock, or heart failure. List only on	cations that caused the	death. Do n	· · · · · · · · · · · · · · · · · · ·					Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition		ION P	NEUMONIA]	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co		n: LUNG DIS	EASE			,	YEARS
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	nsequence o	f):					
1	kecuter and I-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	SEIZURE Due to (or as a co						1	MONTHS
0070	eath certificate be executed attending physician and I for use as the burial-transit	Medical E	L _d								
5 <	ertific ling p	/Mec	IF FEMALE:	7- 16							
	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome pf p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	3 □Ectopic pregnand 5 □ Other (specify) □	ey		- 1	Date of delive Month	ny Day Year
	that t		Part II. Other significant conditions con	tributing to death but no	at resulting in	the underlying cause gi	ven in Part I.	23e. Did 1	tobacco use c	ontribute to th	ne cause of death?
2	quires n sigr uld be	d by					· .	1 🗆	Yes Z	o 3 ☐ Prob	ably 4 □Unknown
5	aw re	olete						24a. Was		b. Were auto	psy findings available
	The I	Completed						auto perfo 1∐ Yes	psy ormezi? 2. No	prior to cor death? 1 ☐ Yes	inpletion of cause of
12	sian: ertifica ctor, 1	Be C	25. Was case referred to medical examiner?				26. Place of Deat				7
5	hysic this co	은	1 Yes 2 No	ospital: 1 Hopatient		Patient 6 BOA	her: 4 Nursing Ho	ome 5 ☐ Resi	idence 6 🗆	Other (Specify	v)
	ending Path. ath. or: After i	ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Ye	ar) 28b. Ti	jury Wo	iry at irk?]Yes 2 □ No	28d. Describe	how injury occ	curred	
	al or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - building, etc. (S	At home, far pecify)	m, street, factory, office		28f. Location (City or To		mber or Aura	l Route Number,
	To the Hospital or Attending Physician: The law requiviting 24 hours affer death. To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should	Medical (29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of more: On the basis of exa and manner stated.	y knowledge, imination and	death occurred at the t l/or investigation, in my	ime, date and place, opinion, death occu	and due to the	cause(s) and , date and plac	manner as st ce, and due to	tated. the cause(s)
	Vithi Vithi To tl	Ž	29b. Signature and title of certifier	$m\Omega$		29c. Licen			29d. Date sig	ned (Month,	Day, Year)
	. 1.4		· Walls	114)			886		Jun	e 15	LUVJ
	104		30. Name and address of person who ro				77 (7) 1 (7) 5 1	MASSA	Ohim	4	
	Sta	ate	31. Date filed (Month, Day, Year)	M. D. 76 Ø 32. Registrar's		ER DRIVE	TOWSON,	MARYL	HIND Z	1504	
	Registi		31. Date filed (Month, Day, Year)	2007	-	Carrie					

Santa Castillo-Heredia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

0.5	00	en ,		1.00	
1	0.0	1	1	5	
Re-sai	0	- 0	1000		

		For State		Cert	ificate of	Death					eg. No.		Lo Tour of Death
Physicia		egistrar I. Decedent's Name (First, M	liddle,Last)							Date of Dea		Year	3. Time of Death
"cal Examir		Santas Cast	illo-Hered:	ia						Month June 14, 2		_	0832 hrs
		la. Facility Name (if not insti	tution, give street and n	umber)	4	b. City, Tow	n, or Lo	cation of	Death			unty of Dea	
		Montgomery Gene				Olney					Montgomery		
			6. Sex	7. Age (In yrs. las	st hirthday)	If Under 1 Year If Under 24Hrs.				8. Date of Bi	rth(MM/DD/	(YYY) g. E	Birthplace (State or
Funeral	- 1	5. Social Security Number			ot birtinday)	Months	Days	Hours	Min.	07-17	-1978	Fore	eign Dominican CountryRepublic
Director		597-50-6550	1 M 2 X F	28	Yrs					0/-1/	-1970		
		Usual Residence of Decede	nt										10d. Inside City Limits
ģ		10a. State 10b. Cou	inty		Town or Locati	ion							1 Yes 2 XX No
_ &	. 1	PR		May	aguez								1 162 2 122 140
/lanc	흱	10e. Street and Number				10f. Zip C	ode				10g. Citizen	of What Co	ountry?
Mar. 28a	Director	EDIF 8, #33				ĺ	00	68-0		Ì	Domin	ican	Republic
death with the Maryland or items 23a or 28a-f show any must be notified at once.							. 61 11	ia Osiai	-2 / Sno	oifu Vac or N	0- 14	Race - Am	nerican Indian, Black,
with ns 2;	<u>ब</u>	11. Marital Status	Aemod	ecedent Ever in U.S Forces?	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					tican, etc.)	White, etc.		
leath r iter	Funeral	1 X Never Married 2	Married 1 Yes	2 X No				Domi	nion	23		. B	Black
her d	H	3 Widowed 4	Divorced If Yes, Give Y	eer .						blic		ecify:	
urs a	g.	15. Decedent's Education	(Specify only highest g	rade completed)	16a. Deceder	nt's Usual O	ccupatio	on (Give k	and of wo	ork done ed)	16b. Kind	of Busines	ss/Industry
2 hou	Completed	Elementary/Secondary (0)-12) College	(1-4 or 5+)	duning n					-,		Oun H	Tome
36 iii 7	Homemaker												ione
with Mer 1	18. Mother's Name (First, Middle, Last)								s Name (First, Middle	, Maiden Sur	name)	
filed Hy	O	Santos Cast	i 110							leredia			
d be fenta	N A P P P P P P P P P P P P P P P P P P									ural Route N	umber, City o	or Town, St	tate, Zip Code)
Delia H. Carmona EDIF 8, 83 Mayaguez PR 00680													
											20c. Loc	ation - City	y or Town, State
F Tites		crematory or other place)								10010=	San	to Do	omingo
ages ages int of		4 Donation 5 Ott		Val	lle Ve	La Lu:	z Ce	em.		23/07			an Republic
Itin it. P it. P ortar		21. Signature of Funeral Se		1358									nation Service
Ea Ea Perm Deps Imp		100	1							Sprin			
	Н	23a. Part I. Enter the disea	se, or complications that	at caused the death	. Do not enter	the mode of	dying, s	such as c	ardiac or	respiratory a	arrest, shock	, or heart	Approximate Interval Between Onset and
Physician /Medical	ľ	failure. List only one	cause on each line.										Death
≟xaminer		Immediate Cause (Final di or condition resulting in de	sease a. Cardia	ac arrhythm	ıta								
	b. Cardiomegaly and biventricular dilatation												
Sequentially list conditions,													
	ine	if any, leading to immediat cause. Enter Underlying (Cause										
	Examiner	(Disease or injury that initi events resulting in death)		as a consequence of	of):								
760, icate be executed physician and the burial - transit		Cvonic researing in security	d.										
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in whe fineral director, page 2 should be detached for use as the build—transi	caj	X UNPENDED #MSNDED, PII, 27, perME, g869, 7/25/07 TT IF FEMALE: 23b. Was decedent pregnant in the 2 Fetal death 3 Ector											
O, e be ysicii buri	ed	IF FEMALE:		es, outcome of pre		, 1, 23,	<u> </u>				23d.	Date of del	
760, ficate be g physical s the buri	 ₹	23b. Was decedent pregna		ve birth	2 1	Fetal death	3	Ectopi	ic pregna	ancy	N	Month	Day Year
Box 687 e death certific the attending	Physicial	past 12 months?		regnant at time of d		Other (Spec	cify)						
Sox leath e atte	Ş.	1 Yes 2 No 9		nknown									the state of doub?
O. Boat the de I by the tached f	님	Part II. Other significant	conditions contributi	ng to death but not	resulting in the	e underlying	cause g	given in P	Part 1.				ite to the cause of death?
, P.O. rres that the signed by	à	h .	11 anemia							1	Yes 2		Probably 4 Unknown
ds, equires een sig	l b									24a. W		24b. We	ere autopsy findings available or to completion of cause of
ords v requi s been should) je										utopsy erformed?	dea	ath?
e faw te has	Completed									1 🗸 Y	es 2 No	1 🗸	Yes 2 No
of Vital Records, ag Physician: The law require the true received the true this certificate has been simeral director, page 2 should be meritimed to the control of the con	ြပ္		medical				26.Place	e of Deatl	h (Check	only one)			
ician s cer	B B	examiner?	Hospital:	Inpatient 2	✓ ER/Outpatie	ent 3 E	AOC	Other ₄	Nursir	ng Home 5	Residen	ce 6	Other:
FV Phys er thi	F	27 Manner of Death			28b. Time		28c. Inju	iry at Wo	rk?	28d. Descr	ibe how injur	y occurred	j
n of ' Iling Ph After t	=	1 X Natural 5	Pending	Date of Injury Month, Day,Yeer)		1	1	Yes 2	No				
ior teath tor:	atic	2 Accident		Place of Injury - At		tract factors	office	huilding	etc	28f Locatio	on (Street ar	d Number	or Rural Route Number, City
Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A	Certification:	3 Suicide 6	Could not be		nome, tarm, s	treet, ractory	y, onice	Dullang,	cto.	or Tov	n, State)		
Pital Disa	l t	4 Homicide		ecify)						1			
Hosp 4 ho			fying Physician: To th	e best of my knowle	edge, death oc	curred at the	e time, d	late and p	place, and	d due to the	cause(s) and	i manner a	is stated.
To the Hos within 24 h	Medical	one) 2 Medi	fying Physician: To th cal Examiner:On the b	asis of examination ner stated.	and/or invest	igation, in m	y opinio	n, death t	occurrea	at the time, t	Jate and plac	,6, 2110 000	3 10 110 00000(1)
5 with 5 m	3 §	29b. Signature and fitle of		ner stated.		29	lc. Licen	se numbe	er				d (Month, Day, Year)
	1 -	101/1/1/	100/11			ı	O.C	.M.E.			June	e 15, 200	07
		100	/ / / /		020		_						
		30. Name and address o		cause of death (Ite	em 23a) or 111 D	enn Stre	et Ra	ltimore	. MD 2	1201			
		Susan Hogan M		edical Examin			ot, Da						
	Stat		y, Year)	Registrar's Sign	ature	all I							
Reg	istra	n 111N 1	9 2887	Contract A	1	30					00115		
DHMH 17 Rev	1/200	1			ORIGI	NAL					OCME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 1:000 Florence Eva Combs June 16 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1403 Oakland Road Reisterstown Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 1 □ M 2 1 F 245-46-9401 101 **Director** April 25 1906 NC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dica Examiner must be notifled at MD Baltimore Reisterstown 1 ☐ Yes 2 ▼ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1403 Oakland Road 21136 USA Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. 1 ∐Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 9 Specify: 3 ₩Widowed 4 Divorced white Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) domestic homemaker nd 2 should be filed walth and Mental Hygiel 27 is marked other the traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mack Irwin permit. Pages 1 and 2 should be Department of Health and Mente Important: If Item 27 is marked any Injury or other traumatic ev Mary Poe ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1403 Oakland Rd., Reisterstown, MD 21136 Mr. Coy Combs (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ NBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial 6-20-07 Elkridge, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Vaige Hought Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** senile Dement /Medical Due to (or as a consequence of): **Examiner** Sphage Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physiclan/Medical the as 1 IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 🗀 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of e Hospital or Attending P 24 hours after death. e Funeral Director: After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

JUN 1 9 2007

ANSURIVA

30. Name and address of person who completed cause of death (Item 23a) [Type, Print)



DHMH 17 Rev 1/2001

51705

29d. Date signed (Month, Day, Year)

Kestminstez, MD 21157

			For	State of Marylan					tal Hygie	ene	107	19	662
			1 - State Registrar		Cer	tificate of	Death			. No.	J U ;	10.5	15.4
н	Physicia	an	1. Decedent's Name (First, Middle, Last	abatl.	Call	ins		_ h	ate of Death Jonth	Day	Year		of Death
	/Medic	al	4a. Facility Name (If not institution, give	JOETH	CO1	4b. City, Town, o	r Location		ine	16 COU	2007 nty of Death	0.5)5 H'''
	Examin	er	Harbor Hos	pital Ce	ntor	Bal-	tim			40. 000	niy or bount		
	Funeral		5. Social Security Number 6. Se		last birthday)	If Under 1 Year	If Under	r 24 Hrs. 8 D	ate of Birth	'oarl	9. Birthr	lace (Stat	te or Foreign
	Director		200–03–8389	[™] ² √ F 93	Yrs.	Months Days	Hours	Min. (/	Month, Day, Y	14	Coui	PA	
	pu .		Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Lo	cation						Od. Inside	City Limits
	Aaryla r eho	ō	MD	N/A	,, , , , , , , , , , , , , , , , , , , ,	Brook.	lyn						es 2□No
	the N	Director	10e. Street and Number			10f. Zip Code			100	. Citizen	of What Cou	ntry?	
	h with		3805 9th Street					21225		US	SA		
	be filed within 72 hours after death with the Maryland that Hyglene and the filed with the medical content the medical Exercises must be incitified at event, the Medical Exercises must be incitified at	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. \	Was Decedent of H	tispanic Or an, Mexica	rigin? (Specify an, Puerto Rical	Yes or No- n, etc.)		Race - Americ		1
36	or It	by Fu	1 Never Married 2 Married	1 ∐Yes 2. No If Yes, Give		1 □ Yes X □ No	Specify	<i>i</i> :		Spe	ecify:	White	د
Ö	hours tural'		3X Widowed 4 □ Divorced 15. Decedent's Edu	Year or Dates:	16a Dece	dent's Usual Occup	pation		16	Sb. Kind o	f Business/In		
Ϋ́	n na	Completed	(Specify only highest grad	le completed)	(Give	kind of work done DO NOT use retire	during mo d)	st of working				,	
2	d with	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Н	omemaker					Own He	ome	
밀	al Hy d other	Bec	17. Father's Name (First, Middle, Last) Ralph E. Scot	+				ner's Name <i>(Fir</i> Goldia			name)		
yla	should tund Ment	L _O	<u> </u>										
Maryland 21215-0036	C1 00 -= 00		19a. Informant's Name/Relationship (T) Patricia E. Colli		4	ng Address <i>(Street</i> 9th Stre				-	wп, State, Zij	(0000)	
	1 end Heelth Iem 27 other ti	1	20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of		Date			on - City or T	own, State)
Baltimore,	Pages nent of I int: If its iry or o		1 ☐ Burial 2/23 Cremation 3 ☐ f 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State		natory or other pla Cremator		06/18/	2007 B	altin	nore Ma	aryla	nd
Ħ	permit. P Departm Importar eny injui		21. Signature of Funeral Service Licens		22	2. Name and Addre	ss of Faci	lity					
Ö	Depariment Department		Viii		1	narles L. 501 E. Fo	ort A	vens ru venue,	nerai 1 Baltim	ore M	D 212:	30	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the deat ne cause on each line.	h. Do not ent	er the mode of dyi	ng, such a	s cardiac or res	piratory arres	t,			mate Between nd Death
}	Physician		Immediate Cause (Final disease or condition	. Seps	is					.,			nown
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	20.00	,					iinr	nown
		9	S-quentially list conditions,	b. Ayper Due to (or as a conseq	TEY	congi	001		No.	nvl		J111	110001
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	CHE	= (Long	256	Te	ri C	A		INK	nown
oʻ	exec en an	Exa	resulting in death) Last	Due to (or as a consec	uence of):	1,000							
8760,	icate be executed physicien and s the burial-transit	dical		d							_		
မ	ertific ling pl	Med	IF FEMALE:	23c. If yes, outcome of pregna	2004					20.4	Date of della		
Вох	death certific e attending p ed for use as	Physician/Me	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 0	ıl death 3 ☐	Ectopic pregnanc	у			230.	Date of deliv Month	ery Day	Year
P.O.	0 0 0	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown									
<u>ب</u> ص	Physicien: The law requires thet the this certificate has been signed by the rail director, page 2 should be detach	by Pł	Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	nderlying cause gi	ven in Part	il.	23e. Did toba	cco use d	contribute to I	he cause	of death?
rds	w require been sig should b	ed b							1 ☐ Yes	2 □ N	o 3□Pro	bably 4	Vinknown
ecc	law re as be 2 sho	Completed							24a. Was an autopsy		4b. Were auto	opsy findin	ngs available of cause of
œ =	The cate h page	Con							perform 1 Yes 2	No No	death? 1 ☐ Yes	2 12 No	
Vita	icien: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		0		ce of Death (Ch	eck only one)			
ð	Phys this ral dir	. To	1 ☐ Yes 2 ☑ No 27. Man, er of Death	1 VInpatient 2L	28b. Time o	11 3LI DOA		Nursing Home 28d.	5 Residen			(y)	
O	ding th. After fune	tlon	1 VNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Wo	rk?]Yes 2[,			
Division of Vital Records,	Attending in death. ector: Alter by the fune	Ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, st	reet, factory, office		28f.	Location (Stre		um <i>ber</i> or Rur	al Route f	Vum <i>ber</i> ,
Ö	s afte si Dire	Certification:	4 Homicide	building, etc. (Speci	(y)				City of Town,	State)			
	To the Hoepital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical		vsician: To the best of my knoiner: On the basis of examina									se(s)
	the F the F mplete	Med	one)	and manner stated.			se number				gned (Month		
	or or or		29b. Signature and title of certifier	n m				001			•		
	10		30. Name and address of person who		m 23a) (Tune				0	urie	e 16	×(10+
	_ ,			dkina, n	10	3001 5	out	h Har	over	S	r. Bo	alti	more
		ate	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature	3001 S m c	arxl	and	2123	25			
	Registr	A. T.		4 1 AT 1997 MARK	_ /								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TEM#26. perPHYS: G868 6/19/07 WS
State of Maryland "Department of Health and Mental Hygiene [] [] 7

For State Registral Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 10:15 AM 2007 Mary Margaret Clements June 15, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminister Dove House If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 26, 1 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 200F 80 1927 Yrs. 215–22–1123 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City. Town or Location 10a. State Show other than "natural", or items 23e or 28a-f showers the Medical Examinar must be multiled at 1 ☐ Yes 2\No Directo Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21221 U.S.A. 34 Berkshire Road Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XX No Specify: Baltimore, Maryland 21215-0036 Specify: ል XXWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Hygiene 10 Meat Cutter Grocery Store 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) nit. Pages 1 and 2 should be fil artment of Health and Mental H ortant: if item 27 is marked ott injury or other traumatic even Be Eva Johnson Lonzo Capps 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7000 Longview Road, Columbia, Maryland 21044 James Clements (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) June 18, 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State permit. Pag Department Important: i any injury o Baltimore, Maryland Holly Hill Mem Grdns 2007 ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service License 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine or Attending Physician: The law requires that the death certificate be executed and Il-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician are the burial-t Division of Vital Records, P.O. Box 68760, Physician/Medical as attending a IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 ☐ Pregnant at time of death signed by the all 5 Other (specify) 9 Unknown 9 ☐ Unknowń 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 20 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: Nursing Home Residence 6 □Other (Specify) 1 Tes 2/1/10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation completely filled in by the Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOCE Registrar's Signature Day, Year) 31. Date filed (Month ANGE! State JUN 1 9 200 Po SERI Registrar

			For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of He rtificate of D		-	E 0 0 1	1966:
			Decedent's Name (First, Middle, Last	it)		timodic or D	Julia	2. Date of Deat		3. Time of Death
ı	Physici /Medio		1	Benjamin	Craw	ford, Jr.		June June	13 200	
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or L	ocation of Death		4c. County of De	
			6886 Baltimore			Linthic			Anne A	
	Funeral Director		210 30 2009	ex 7. Age OXIM 2□ F	(In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 24	, 1950 Ma	irthplace (State or Foreign Country) aryland
	and w	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryl f • hg	호	Maryland Anne	Arunde1	Linthic	um				1 ☐ Yes 2 🖾 No
	r 28a	lrec	10e. Street and Number	Į.		10f. Zip Code		1	0g. Citizen of What (Country?
	th wit	a D	6886 Baltimore	Annapolis	Blvd.	210	90		U.S.A.	
	r dea	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Bfack, Wh	
Maryland 21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Iteme 23a or 28a-1 ehow ha Mudical Exacilian must be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 XDivorced	1 ∏Yes 2 □ No If Yes, Give Year or Dates:	>		Specify:		Specify: W	
5	"natu	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occupat kind of work done du	ion iring most of worki	ng	16b. Kind of Busines	s/Industry
12	withir ene. than	d m	Elementary/Secondary (0-12) unknown	College (1-4or 5+	.)	00 NOT use retired) nter – Pin	Strining	o	Aut	0
9	Hygi Hygi other	ပိ	17. Father's Name (First, Middle, Last)				18. Mother's Name			
an	lid be Rental	To Be	Benja	min Crawfo	rd Sr.		Mary 1	Harvath		
ary	should have		19a. Informant's Name/Relationship (7		19b. Mailir	ng Address (Street an	nd Number or Aura	l Route Number	City or Town, State,	Zip Code)
	and 2 setth n 27 i		Grady Crawford	/ Brother	6886 20b. Place of Dispo	Balto. An	napolis l	Blvd. L	inthicum,	MD. 21090
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural; or iteme 23a or 28a-f ehow any injury or other treumatic event, the Modical Extended must be notified at once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify)		20c. Location - City of Baltimore	or Town, State , Maryland		
Balti	permit. Depertra Importe eny inju		21. Signature of Juneral Service Libert	Darie		Name and Address				ce, P.A. yland 21225
			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	plications that caused to	he death. Do not ent					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CACO	ic Am	L Dania				Onset and Death
	/Medical Examiner		resulting in death)		consequence of):	J	1			3 4 5
	Lammer	_	Sequentially fist conditions, if any, leading to immediate		consequence of):	14				1 year
	led sit	nlne	cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence or):					in year
	flicate be executed g physicien and as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):	<u> </u>				10 J 4NJ
68760,	e be o /sicier e buri		(d.						
		ledical		<u> </u>						
P.O. Box	The law requires that the death certifies has been signed by the ettending page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetaf death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
	that ned by deta		Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying cause given	in Part I.	23e. Did tob	acco use contribute	to the cause of death?
rds	quires in sign	g D	END STORE R	ENAL Dis	ease - o	h Disty	2-2	1 □ Ye	s 2 No 3 F	Probably 4 Unknown
Division of Vital Records,	law reas bee	Completed by	03×1	week	lass Die	olesis J.	me 11,20	24a. Was a	n 24b. Were a	autopsy findings available
ž	The lav	E						autops perform	prior to ged? death?	
ita	etor.	Bec	25. Was case referred to medical examiner?				26. Place of Death			-3-
×	hysic his co	၉	1 es 2 No		t 2 ER/Outpatien		4 Inursing Hor		nce 6 Other (Sp	ecify)
D C	ling P	ë ë	27. Manner of Death 1 Denatural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	Work?		28d. Describe ho	w injury occurred	
isic	death death ctor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	-	y - At home, farm, str		as 2 No	Of Location (St	reet and Number or F	Duml Pauta Numbar
<u>≥</u>	al or Attend s after death of Director;	Certification:	4 Homicide determined	building, etc.		eet, ractory, onice	-	City or Town		nural noute Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete ha completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one) 2 Medical Exer	ysician: To the best of tiner: On the basis of and manner state	examination and/or inv	occurred at the time vestigation, in my opin	, date and place, a nion, death occurre	and due to the ca ed at the time, da	use(s) and manner ate and place, and du	as stated. ue to the cause(s)
	To the within To the comp	Ň	29b. Signature and title of certifier		2) - ^	29c. License			9d. Date signed (Mor	
}			Chilerate	rely well	In M.D	1)34	1334		Ine 13	14 2007
	Ì		30. Name and address of person who control of the c	completed cause of de		Print) 3/5 N	CALVE	CT 35.	Baltric	12 2007 re, 71302
	Sta	te	31. Date filed (Month, Day, Year)	. Registrar	's Signature	A [‡] A	•			
	Registr	ar	JUN 1 9 200	7 Beauces	's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 8 per fb (869 7-23-07 yt)
State of Maryland (869 repartment of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician Keira 2:28 AM Dickson 6 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University of Mayland Medical 5. Social Security Number | 6. Sex | 17. Age NIA Center Baltmore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, June 1, 9. Birthplace (State or Foreign **Funeral** Days Hours 214-39-9751 1 □ M 2 🔽 1993 maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 √es 2 No Funeral Director ma. Ltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ģ black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Student Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be 10KS0 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Apt 107)lene 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Kine 4 ☐ Donation / 5 ☐ Other (Specify) 21. Signature of uneral Service Ucens merch treneral Hone eto, ma. 21229 23a. P. 1. Filer the disease, or complications that caused the death. Do not enter the mide of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line.

Immediate cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): 14 years Examiner AIDS Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner nycobacterium avium intracellulare unknown Hospital or Attending Physician: The law requires that the death certificate be executed Disseminated and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical 23c. if yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. δ 217 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed this certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: To the Hospina. Switch death.

To the Funeral Director: After this completely filled in by the funeral director. 1 Inpatient 2 ER/Outpatient 3 DOA 1 TYes Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 21152 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4526 Weld Keswick Rd. Baltimore MD 21210 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

p
09289
. Box
P.0
Records
Vital
of
Division

		F	Please 1	ype or Prir					•		C	
		For State Registrar		State of Ma	aryland		artment of F <i>rtificate of</i>		ınd Mental H	Hygien Reg. №	to U U I	19665
	8	1. Decedent's Name (First,	Middle, Last,)					2. Date of			3. Time of Death
Physicia		Gelacio E.	Dela	Cruz, Jr					Month		ay Year	6.30 P ^M
/Medic		4a. Facility Name (If not ins					4b. City, Town, o	er Location o	June		c. County of Dea	
Examin	er						Baltim		1 200			
	ė.	9502 Hick 5. Social Security Number	cory Hu		e (In yrs. la	et hirthday)	If Under 1 Year		24 Hrs. 8. Date of	Birth	Baltimo	
Funeral		5. Social Security Number		M 2□F	56	Yrs.	Months Days	Hours	Min. (Month,	Day, Yea		thplace (State or Foreign ountry)
Director		214-82-1027 Usual Residence of Decede							Jan.1	6, 19	51 Phi	llipines
and *	ł		County		10c. City,	Town or Lo	ocation					10d. Inside City Limits
sho	5	MD Bal	timore		D-1-	timore						1 ☐ Yes 2 ☐ No
filed within 72 hours after death with the Maryland Hyglene. uther than "netural", or itams 23a or 28a-f show ant, the Medical Evanther must be notified at	Director		CIMOLE		рат	CIMOL				10- 0		
or 2	Dir	10e. Street and Number					10f, Zip Code			10g. C	Citizen of What Co	ountry?
23£	E	9502 Hickor	y Hurs	st Dr.			21236				USA	
ams erm	Funeral	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S	3. 13.	Was Decedent of H	lispanic Orig	gin? (Specify Yes or , Puerto Rican, etc.)	No-	14. Race - Ame Black, Whit	
after or it	F	1 Never Married 2		1 ☐ Yes 2 ☐ If Yes, Give X		1	1 ☐ Yes 2 ☐ No	Specify:			0	
rai',	l by	3 ☐ Widowed 4 ☐ Div	vorced	Year or Dates:			X	оросу.			As	sian
72 h	tec	15. De (Specify only	cedent's Edu	cation		16a. Dece	dent's Usual Occup	ation	of working	16b.	Kind of Business	/industry
thin "	ğ	Elementary/Secondary (College (1-4or 5	5+)	life.	DO NOT use retire	d)	oy			
d wil	Completed	12+			,		Civil Eng	ineer		Sta	te of Ma	ryland
Hy Othe	Bec	17. Father's Name (First, N	fiddle, Last)					18. Mothe	r's Name (First, Mic	ddle, Maide	en Sumame)	
ld be enta ked ic av	ToB	Gelacio	Dela (Truz				Ma	rciana Er	ese		
should be ind Mental s marked c umatic av	-	19a. Informant's Name/Re				19b. Maili	ng Address (Street		r or Rural Route Nu		or Town, State,	Zip Code)
d2: thar trau		Diana Dela (ruz-Is	offe / Sic	ter	9415 1	Re11he11	Dr	Baltimore	Md	21236	
1 and Health am 27 thar tr		20a. Method of Disposition		arre / bra		1	osition (Name of	DI.,	Date		Location - City or	Town, State
Pages nent of H ant: if its ary or of		1 X Burial 2 ☐ Crem	ation 3 🗆 F		Car	metery, cre	matory or other pla of Faith	Com 6	/18/2007		Baltimore	
. Pa tmen tent jury	- 24	`4 □Donation 5 □ Ot		-	Gar					-		
permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items any injury or othar traumatic avant. Ite Medical Evaniret mongo.		21. Signature of Funeral S	ervice Licens	00		2:	2. Name and Addre	ss of Facilit	y Schimune	k Fun	eral Hor	ne, Inc.
907 20	1.7	· a	a			9	705 Belai	r Roa	d, Nottin	gham,	. Md. 2	1236
Pnysician /Medical Examiner		23a. Part1. Enter the dises shock, or heart failure immediate Cause (Final disease or condition resulting in death)	e. List only o	ne cause on each li a	ne. Zsta	tic	- 1		ocer			Interval Between Onset and Death
rate be executed shysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):										
e as	Mec	IF FEMALE:							-			
To the Hospital or Attanding Physicien: The law requires that the death certificate bewithin 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur	by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)							23d. Date of de Month	olivery Day Year		
s that ned b	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cau					inderlying cause giv	e given in Part I. 23e. Did tobacco use contribute to the cause of death?				
quire n sig nd blu									1	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown		
w rec bee	Completed								24a. V	24a. Was an 24b. Were autopsy findings availa		
has has	m					-				utopsy erformed?	death?	completion of cause of
r: Thicate									1 🗆 Ye		lo 1 □ Yes	s 2 No
ician sertif ector	Be	25. Was case referred to n examiner?					0#		of Death (Check or			
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director. page	itlon; To		Pending investigation	Hospital: 1 ☐ Inpatie 28a. Date of Inju (Month, Da		ER/Outpatie 28b. Time o Injury	of 28c. Inju Wo	ry at			6 □Other (Spe jury occurred	ecify)
tal or Attar s after dea el Director ed in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							dural Route Number,			
tha Hospi in 24 hou. Iha Funer pletely fill	edical	(Check only 2 Moone)	edical Exami	rsician: To the best iner: On the basis of and manner st	of examinati		ovestigation, in my	opinion, dea		me, date a	ind place, and du	e to the cause(s)
To T COUNTY	Σ	29b. Signature and title of	certifier	aseul	Low	nl	29c. Licens		30		Date signed (Mon	
6		30. Name and address of p	ALLA	ompleted cause of o	death (Item	23a) (Type,	Print) S	Frwa	OOD, I	BRZ	AIR 2	5-2007
Sta Registr	4	31. Date filed (Month, Pay	V 1 9 2	007 32. Fegisti	rar's Signati	F A	sel					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Year 8:00 PM **Physician** Joonis 200 une /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A John Hopkins Hospital Baltimore City If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Feb. 6, 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1**⊠** M 2□ F Yrs. 66 Director 219-26-6854 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Director Westminster Carroll 28e-f Examiner must be notifie 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 USA 21158 permit. Pages 1 and 2 should be filed within 72 hours after deeth v Department of Health and Mental Hygiene. In the 23 lampstent: If them 27 lamarked other than "natural", or Itama 23a eny Injury or other traumatic event, Ita Medical and once. 731 Young Way Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 🛛 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Service & Gas Station Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Penelope Soffos Doonis Nicholas ု 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hudson, Florida 34669 Louis N. Doonis/Brother 13712 Pimberton Dr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6/18/07 Baltimore, Maryland Greek Orthodox Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licenses Towson, Maryland 21204 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumonia days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Division of Vital Records, P.O. Box 68760. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 051 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ◯ No 24a. Was an autopsy 1 ☐ Yes 2.MNo certificete 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 > npatient 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death After 1 Natural s after decay After Director: After 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier completely (Check only one) 1 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 30. Name and address of Arson who completed cause of death (Item 23a) (Type, Print) 600 Xion 9 North

State Registrar

31. Date filed (Month, Day, Year)

2007

DHMH 17 Rev 1/2001

ORIGINAL

32@Registrar's Signature

			1 - For State of Maryland			of Health of Deat		lental Hy	giene Reg. No.	07	19661
	Physic	ian	1. Decedent's Name (First, Middle, Last)					2. Date of De	ath Day_	Year	3. Time of Death
	/Medi	cal	Vera M. Enright					June	15	2007	82 AM
	Examir	ner	4a. Facility Name (If not institution, give street and number) BEI-AIR HEALTH & Rehab		4b. City, To	wn, or Location	on of Death		4c. Coun	ty of Death	1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las.	EN H	If Under 1		ler 24 Hrs.	8. Date of Bir	th	9. Birtho	place (State or Foreign
	Director		145-05-6818 ^{1□M 2} ▼F 88	Yrs.	Months D	Days Hour	s Min.	8. Date of Bir Month Da 10-31-	1918	New	place (State or Foreign http) Jersey
	D .		Usual Residence of Decedent 10a. State 10b. County 10c. City, 7	Town or Los	ation						Od Inside City Limits
	Aarylan Febow	ō		L Air	ation						0d. Inside City Limits 1 ☐ Yes 2 No
	28a-	rect	10e. Street and Number	L AII	10f. Zip Co	ode			10g. Citizen o	f What Cour	ntry?
	h with	E D	1415 St. Frances Rd		2101.	5			U.S.A		·
	72 hours after death with the Maryland 72 hours after death with the Maryland Instural', or Items 23s or 28s-1 ehow dical Examination must be incitified at	Funeral Directo	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Deceden Yes, specify	t of Hispanic Cuban, Mexi	Origin? (Sp.	ecify Yes or No Rican, etc.))- 14. R	ace - Americ	
96	S afte	by FL	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No		☐ Yes 2X					ify:Whit	
ξ	tural	ed t		6a. Deced	ent's Usual C	Occupation			16b. Kind of	Business/Inc	dustry
7 5	within 72 ene. then "n	piet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give I	and of work of NOT use i	done during m retired)	ost of work	ing	100. 14.110 01	200111000	2030.9
2	filed wit Hygiene Sther th	Completed	12	ietic	ian				GreenH	111 N	ursingHome
20	be fill Hy of h	Be	17. Father's Name (First, Middle, Last)						, Maiden Suma	am <i>e)</i>	
2	should ind Men ind marke umatic	2	Abraham Gernert 19a. Informant's Name/Relationship (Type, Print)	10b Mailin	Address (S		ah Key		er, City or Tow	n Stata Zin	Codel
2	and 2 s and 2 s ealth an m 27 ls		Dave Enright (Son)						MD 210		Code)
9	it Hea		20a. Method of Disposition 20b. Plac		ition (Name atory or other			Date	20c. Location		wn, State
Ē	Pages nent of I		1 2 Danial 2 22 Orbination 5 Citamoval note 5 tate		remato		06-18	-2007	Baltime	ore. M	aryland
Baltimore Manyland 21215,0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-1 ehoverly follow or other traumatic event, it a Madical Examination in the inclinical and once.		21. Signature Figure Section censee	22.	Name and A	Address of Fa	cility Sch	imunek	Funera	1 Home	of Bel Air
	20539		74764			_			el Air,	MD 2	1014
•	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequent of the conditions of the condition of the conditions of the	sis	r the mode o	it dying, such	as cardiac (or respiratory a	rrest,		Approximate Interval Between Onset and Death
ARIE 8760	cate be executed only sician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence								
A MA	the death cert by the attending ached for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deatl	ath 3⊡i	Ectopic pregr Other (speci		- 0010			ate of delive	ory Day Year
(ER)	w requires tha been signed should be det	Ď	Part II. Other significant conditions contributing to death but not resulting	nt I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown						
> 2	The law re tate has be page 2 sho	Completed						24a. Was autop perfo	osy ermed/?	. Were auto prior to cor death? 1 \(\subseteq \text{Yes}	psy findings available inpletion of cause of
1-12	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?			26. Pla	ace of Death	Check only			
7	. × × ×	ပ္	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER						dence 6 □O		1)
111	an and an an an an an an an an an an an an an	ig	1, Natural 5 ☐ Pending (Month, Day Year)	b. Time of Injury	28c.	Injury at Work?		28d. Describe	how injury occu	urred	
ON CO	or Attending after death. Director: After	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury • At home building, etc. (Specify)	, farm, stre				28f. Location (City or To		nber or Rura	l Route Number,
ク	Hoepita 24 hours Funeral tely filled	edicai C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	dge, death and/or inve	occurred at t	he time, date my opinion, d	and place, leath occurr	and due to the ed at the time,	cause(s) and n	nanner as st	ated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			icense numbe			29d. Date sign	ed (Month,	Day, Year)
			Pa vole			292	45		6/19	5/0/	>
	3		30. Name and address of person who completed cause of death (Item 23 SHILP) KHOSLA 206 HA	a) (Type, P	rint) T#10	12, B	EL	AIR .	WD	210	14
	Sta Registr	_	31. Date filed (Month, Day, Year) 32. Begistrar's Signature JUN 1 9 2007	Con	W.						

Registrar DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760,

Division of Vital

32 Registrar's Signature

C88 Poole Rd, Westminster

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar	te of Maryland / Dep <i>Ce</i>	partment of Health a ertificate of Death		giene Reg. No. 2 A T	17 18670
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Do	eath _	3. Time of Death
	/Medi	cal	Dorothy E. Edmonds 4a. Facility Name (If not institution, give street a	and according of	th City Taylor and posting	June 1	3, 2007	5:30 P ^M
	Examir	ier	Blakehurst Health Ce		4b. City, Town, or Location of Towson	oi Deatri	4c. County of Baltime	
	Funeral Director		5. Social Security Number 6. Sex 116-09-3810 1 M 2	7. Age (In yrs. last birthday 91 Yrs.	/) If Under 1 Year If Under Months Days Hours	24 Hrs. 8. Date of Bi Min. (Month, D. 12/31/	rth o	Birthplace (State or Foreign Country) New York
	/land low at		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	e Man 3a-f sh tiffied	ctor	MD Baltimore	Towson				1 □Yes 2 □No
	with the a or 2 the no	Dire	10e. Street and Number 1055 W. Joppa Road		10f. Zip Code 21204		10g. Citizen of Wha	at Country?
'	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11 Marital Status 12. Wa	s Decedent Ever in U.S. 13. ned Forces? Yes 2 X No	. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexicar	gin? (Specify Yes or No n, Puerto Rican, etc.)	USA 14. Race - Black,	American Indian, White, etc.
Baltimore, Maryland 21215-0036	ours a	þ	- V	es, Give ir or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify:	white
15-0	n 72 h "natu edical	letec	15. Decedent's Education (Specify only highest grade comp	leted) (Give	edent's Usual Occupation e kind of work done during mos DO NOT use retired)	t of working	16b. Kind of Busin	ness/Industry
212	d withi giene. er than the M	Completed	Elementary/Secondary (0-12) Coll	lege (1-4or 5+)	ol Teacher		Education	on
pu	be filed ntal Hygi od other event, tl	Be	17. Father's Name (First, Middle, Last)			er's Name (First, Middle	, Maiden Surname)	
IIJ	should be and Mental s marked o	2	Frederick Grant 19a. Informant's Name/Relationship (Type. Prin	nt) 19h Mail	Ne11		or City or Town Ct	ote Zin Conto
, ⊠	and 2 sealth ar		Craig Edmonds /		3 Spring Creek			
ore	Pages 1 an nent of Heal ant: If item 2 ury or other		20a. Method of Disposition 1 ☑ Burial	20b. Place of Disp	osition (Name of ematory or other place)	Date	20c. Location - Cit	
Ħ	artmen artmen ortant: injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fund Seven Licensee		11ey Mem Gardens		Timonium,	
Ba	permit. Departr Importa any inji		1 Chi Cans		uck Towson Fund	*		ork Road MD 21204
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death. Do not en	nter the mode of dying, such as	cardiac or respiratory a	rrest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Treun	MA			Inset and Death,
	Examiner			Helin Le to (gras a consequence of): Chronic Obst.	nextue Pulm	Drawy Drie	me	10 yrs
	De te	iner	cause. Enter Underlying	ue to (or as a consequence of):				
6x	tificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	ue to (or as a consequence of):	-		<u> </u>	
£8260, A	ate be nysician he buri	edical	d					
	sertifica ding ph		IF FEMALE:	o cutoens of necessaria			1	
. Box	death of attended for us	Physician/M	in the past 12 months?	Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of Month	f delivery Day Year
P.O.	at the	Phys	9 ☐ Unknown	Unknown				
Vital Records,	The law requires that the death certif tte has been signed by the attending bage 2 should be detached for use as	ρ	Part II. Other significant conditions contributing	g to death but not resulting in the u	ınderlying cause given in Part I.	23e. Did t		te to the cause of death? Probably 4 □Unknown
Š	has has	Completed				24a. Was	osy prio	re autopsy findings available to completion of cause of
<u>a</u>	siclan: Th certificate rector, pag		25. Was case referred to medical		26 Place	1□ Yes		Yes 2 No
<u>></u>	Physick r this cer ral direct	To Be	examiner? 1 ☐ Yes 22 No Hospital:	1 Inpatient 2 ER/Outpatien	Other and	of Death (Check only or rsing Home 5 Resident Re		Specify)
o U O	ding P .r After t		1. Natural 5 ☐ Pending	Date of Injury 28b. Time of (Month, Day Year) Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ N	28d. Describe I	now injury occurred	
Division or	Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certifica tely filled in by the funeral director; t	Certification:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e.		Street and Number o vn, State)	r Rural Route Number,		
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	ledical C	(Check only 2 Medical Examiner: On	o the best of my knowledge, deat the basis of examination and/or in manner stated.	th occurred at the time, date and	d place, and due to the th occurred at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)
	To the within 2 To the complet	2	29b. Signature and title of certifie # Cutoff	TUMO	29c, License number		29d. Date signed (M 06/14/2	
	4		30. Name and address of person the completed TRECHEN W. THE PORT I	cause of death (Hem 23a) (Type,	Printy Les Street	Baltimos	e, MD:	21212
	Stat Registra	е		32 Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 0530 Edlen June 17 2007 Rosa /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE AUGSBURG LUTHERAN NURSING HOME BALTIMORE 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 1 □ M 2 □ F 231-46-1679 89 Director 09-12-1917 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County a or 28a-f show be notified at 1 X Yes 2 □ No MD BALTIMORE RANDALLSTOWN Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 4212 HERRERA CT. 21133 ral", or items 23a Examiner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married "natural", or 1 ☐ Yes X☐ No Specify: BLACK Baltimore, Maryland 21215-0036 þ ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 HOUSEWIFE HOME is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARIAH SHORT PETERSON MILTON PETERSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 9921 HOYT CIRCLE, RANDALLSTOWN, MD 21133 LINDA ARTHUR/DAUGHTER 20a. Method of Disposition mercy sear church cem. 06/23/07 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WARFIELD, VA 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Service Licenses 1701 LAURENS STREET, BALTO., MD 21217 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** tears Mentensive disease or condition resulting in death) /Medical onsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) I ☐ Yes 2 No 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: A Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2Æ No 1 Inpatient Certification: To After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 Natural 1 TYes 2 □ No 2 Accident within 24 hours after death To the Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide filled in by 4 Homicide 127 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier use of death (Item 23a) (Type, Print) 30. Name and address of person who com Main Bodis trar's Signature 31. Date filed (Month, Day, Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** ROSE VIC Ellis JUNE 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Randallstown Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 💢 F Director 151-05-6421 89 6-26-1917 N.IUsual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. tem 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐XNo Director Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 10799 Hickory Ridge Road 21044 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ X0 o If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify þ Specify:White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Manhattan Shirt Elementary/Secondary (0-12) College (1-4or 5+) 12th Seamstress Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Karl Kolasa Katherine Monash 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karyl J. Lester/Daughter 6154 Shining Rock, Columbia, MD 21045 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donarion 5 ☐ Other (Specify) 6/19/07 Baltimore, MD 22. Name and Address of Facility Wylie F/ H P.A. of Balto. 21. Sign July of Funeral Service Licensee 9200 Liberty Rd., Randallstown, MD 21133 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of) Examiner RIGHT Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of burial-trar Due to (or as a consequence of): physician sthe burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 4□Pregnant at time of death 5 ☐ Other (specify) a□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEFICILE icate has been sig r, page 2 should b 2 No 3 Probably 4 Unknown 1 Tyes Was at autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has Eplacemen Conors 1∐ Yes 25. Wa case referred to medica examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes Medical Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide

Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760;

Baltimore, Maryland 21215-0036

Hospital or Attending n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral funeral filled in funeral filled in funeral funeral filled in funeral funeral filled in funeral filled i

To th. within 2. To the Fu

1 Registrar

31. Date filed (Month, Day, Year) State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NA EUREN Registrar's Signature

and manner stated.

1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D19507

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Voar Doris Franklin 2007 June 18 5:40 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Futurecare Canton Baltimore N/A Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAR 1 1933 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 **Funeral** Days Hours 1 ☐ M 2 🕱 F Maryland 74 Director 213-30-2620 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 TYYes 2 □ No Director N/A Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2601 Madison Avenue, Apt. 1007 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: **Black** Completed by 3 Widowed 4 Divorced 7 is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) : 1 and 2 should be fill Health and Mental H tem 27 is marked oth Be UNK UNK Dorothy Dixon မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2601 Madison Avenue, Apt. 1007, Baltimore, MD 21217 item 27 other t Linwood Franklin - husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 6/18/2007 Baltimore, MD 21. Signature of Funeral Service Licensee H. Williams Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cancer Ovarian /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as IF FEMALE ase 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached t 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 2 No 3 Probably 4 ☐Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an page 2 has autopsy perform certificate 1□ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA ို 1 ☐ Yes 1 Inpatient this funeral c 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Hospital or Attending Injury ospital ... 4 hours after dea... -ral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hours.
the Funeral Directory filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) completely and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Restatown ND 21136 Nandana 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month 17 Pauline | Farnese June 2007 4:30 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB 17 1925 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🖫 F Hours Min. 226-28-7081 82 Virginia Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 No Director MD Anne Arundel Harwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be re 1501 M Flanders Lane 20776 Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "naturat", or Items 23s **WSA** Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Completed by Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Customer Representative Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Antonio ပ Farnese Carmella Foleno 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anibole Farnese - brother 1501 M. Flanders Lane, Harwood, MD 20776 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages I Department of I Important: If Ite any Injury or ot 1 ☐ Burial 2 Tremation 3 ☐ Removal from State Metro Crematory, Inc. 6/18/2007 4 □ Donation 5 □ Other (Specify) Baltimore, MD 22. Name and Address of Facility.

Cremation Society of Maryland, Inc.
299 Frederick Road, Baltimore, MD 21. Signature of Funeral Service Licensee H. Williams 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Due to (or as a consequence of): differentiated adenocarcinom months /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sunsequence of) Examine burial-tras law requires that the death certificate be exec Due to (or as a consequence of): Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 obstructive pulmonary 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Be Completed page 2 should Cerative colitic 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 2 9 No 1□ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 060390 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) PRINCE FREDERICK. MD 100 ADEEB JABER HOSPITAL RD. 32. Registrar's Signature 31. Date filed (Month, Day, State 19 200 Registrar

DHMH 17 Rev 1/2001

3altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

6

State Registra

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

June 14, 2007

30. Name and address of person who completed cause of death (Item 23a)

00

Assistant Medical Examiner

32 Registrar's Signati

29b. Signature and title of certifier

Tasha Greenberg MD.

31. Date filed (Month Jan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 12:40 am 2007 Precious Carlden Freeman Sr. May 21 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's St. Thomas Moore Nursing Home Hyattsville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday, Months Days Hours 1**√** M 2□ F 248-46-7731 75 January 1,1932 SC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code

20019

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domistic Techecian

1 ☐ Yes 2X No

20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeak Crematory

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

U.S.A.

Private

Beltsville

18. Mother's Name (First, Middle, Maiden Surname)

58th St. #302, Washington, DC 20019
tion (Name of atory or other place)

June Day 200 70c. Location - City or Town, State

22. Name and Address of Facility D.L. McLaughlin Funeral Home 2019 MLK Jr Ave, SE Washington DC 20020

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

<u> Mary Lou Gilchrist Freeman</u>

Race - American Indian, Black, White, etc.

Specify: Black

Dupont East Hotel

16b. Kind of Business/Industry

- Appelo	Physician /Medical	8 9	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of):	Onest and Death
,092	executed in and ial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c	
O. Box 68760	ne death certificate be executed the attending physician and hed for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1	23d. Date of delivery Month Day Year
Records, P.	The law requires that the ditte has been signed by the sage 2 should be detached	Completed by Phy	Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
a	CO Suda		25. Was case referred to medical	OC Place of De	1 Yes 2 No 1 Yes 2 No No No No No No No No
Vital	Physician: this certifical director,	o Be	examiner?	La seriest	Home 5 ☐ Residence 6 ☐ Other (Specify)
	ding J. After funer	tion: T	27. Manner of Death 1	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
Division	i gift	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
	o the Hospital vithin 24 hours a o the Funeral I ompletely filled	Medical C	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best of my knowledge, death occurred at the time, date and plac miner: On the basis of examination and/or investigation, in my opinion, death occ and manner stated.	ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)
	ro the within 2 Fo the comple	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

110

DHMH 17 Rev 1/2001

State Registrar 1 - For State Registrar

10a. State

110

11. Marital Status

58th

1 Never Married 2 Married

¥☐ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses

31. Date filed (Month, Day, Year)

11

20a Method of Disposition

St SE #302

15. Decedent's Education (Specify only highest grade completed)

Willie Green Freeman

Lillie F. Nellons

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:

College (1-4or 5+)

DC

Director

Funeral

Completed

Be

2

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

DEVORE MD4203 OD genson mr Rd Ha Itsuille MD 20181

DHMH 17 Rev 1/2001

Registrar

Leanor

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene [] [] 7

		ı	4 101	partment of Health and Me ertificate of Death		enê 007 19678) . No.										
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death										
	/Medic		ELVIE ELIZABETH FRANCIES		JUNE 1	6, 2007 10:30a M										
	Examin	er	4a. Facility Name (If not institution, give street and number) 2631 BECKLEYSVILLE ROAD	4b. City, Town, or Location of Death MILLERS	ı	4c. County of Death BALTIMORE										
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign										
	Funeral Director		218-05-2240 1 M 2 TOF 96 Yrs	Months Days Hours Min.	ochin 22 ;	9. Birthplace (State or Foreign Country) MARYLAND										
	and **		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	Location		10d. Inside City Limits										
	a-f sho	ctor	MD BALTIMORE MILLE	RS		1 ☐ Yes 2 No										
	th with the 23a or 28 int be not	Funeral Director	10e. Street and Number 2631 BECKLEYSVILLE ROAD	10f. Zip Code 21102	1 -	s. Citizen of What Country? SA										
980	y within 72 hours after deeth with the Maryland liene. r than "natural", or Itams 23a or 28e-f show the Medical Examana must be molfiled at	ρ	11. Marital Status 1 Never Married 2 Married 1 Never Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexican, Puerto F Yes 2 No Specify: 	city Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE										
5-0	72 hc	eted	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work in	ng 16	b. Kind of Business/Industry										
121	within sene.	Completed	Flamostary(Connectory (0.12) Callago (1.4ec F.)	e. DO NOT use retired) EMAKER		WN HOME										
Maryland 21215-0036	be filed stai Hyg ad othe event.	To Be C	17. Father's Name (First, Middle, Last) STEPHAN TABELING	18. Mother's Name ELVIE BA		iden Sumame)										
ary	d 2 should th and Men 7 is marks traumatic			ailing Address (Street and Number or Rural												
	C = N L			6 BECKLEYSVILLE												
nore	of H fiter		1 Burial 2 □ Cremation 3 □ Removal from State DIII. ANF.	rematory or other place)	20,200	7 TIMONIUM, MD										
Baltimore,	permit. Pag Depertment Importent: i any injury o		1 Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee			ENKINS & SONS CO.										
<u> </u>	207 29		A Monaco	16924 YORK RD.												
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final	enter the mode of dying, such as cardiac of	r respiratory arres	t, Approximate Interval Between Onset and Death										
	/Medical Examiner		disease or condition resulting in death) a. Due to (or as a onsequence of):	er so wasis		Syri										
8760,		ysician/Medicai Examiner	icai	cai	icai	icai	icai	icai	icai	cai	cai	cai	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):			
O. Box 6	The law requires that the death certificate be executed tite has been signed by the attending physician and page 2 should be detached for use as the burial-transit															
S, P	Ires that signed b	by	Part II, Dther significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		cco use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown										
Records,	w requir	eted	ASCIA		24a. Was an	24b. Were autopsy findings available										
I Rec		Completed	ASCVA		autopsy performe	prior to completion of cause of										
Vital	Physicien: Th rthis certificate ral director, pag	Be (25. Was case referred to medical examiner?	26. Place of Death	(Check only one)											
of/	S S D	70	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa 27. Manner of Death 28a. Date of Injury 28b. Tim		ne 5 Pesiden 28d. Describe how	ce 6 Other (Specify)										
uc	ding Phy h. After thi funeral	ion	1 Natural 5 Pending (Month, Day Year) Inju		200. Describe now	Injury occurred										
Diviston	the Hospitel or Attending hin 24 hours efter death. the Funeral Director: After hipletely filled in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)		28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)										
	To the Hospitel within 24 hours e To the Funeral Completely filled		29a. Certifier (Check only (Ch	eath occurred at the time, date and place, a	and due to the cau	ise(s) and manner as stated.										
	the H the F mplete	Medical	one) and manner stated. 29b. Signature and title, of certifier	29c. License number		d. Date signed (Month, Day, Year)										
	with To		AN	11887-7	230	6/18/07										
			30. Name and address of person who completed cause of death (Item 23a) (Ty		Parkton	MA 21175										
	Sta Regist		31. Date filed (Month, Day, Year) JUN 1 9 2007 32. Degistrar's Signature	harles	y 											
	3	100	ANTI A CONTRACT OF THE PARTY OF													

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 18 per fh 9869 7-11-07 vt
State of Maryland / Plenariment of Health and Mental Hygiene

			State of Maryland	-	rtment of H tificate of I		Mental Hy	00	0.7	10170
m			Registrar 1. Decedent's Name (First, Middle, Last)	001	incate of t	Death	2. Date of De	Reg. No	U.I	3. Time of Death
	Physicia		Lynn Gregg	June	Day	Year 2007	8:02 PM			
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death							
			University of Maryland Medical Center Bultimore							
	Funeral		5. Social Security Number 6. Sex 12 M 2 □ F 7. Age (In yrs. Ia: 087–32–1069 67	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	1940	9. Birthp	place (State or Foreign ntry) necticut
H	Director		Usual Residence of Decedent				ray 5,	1340		
	how at		Now	Town or Loc					1	I Od. Inside City Limits
:	Ba-fs	Director	York Columbia	Chatha	am / Vala	tie				1 □ Yes 2 □ X No
3	a or 2	Dire	10e. Street and Number		10f. Zip Code			10g. Citizen of		•
:	eath ns 234 must	Funeral	1502 County Route 28 11. Marital Status 12. Was Decedent Ever in U.S.	13 V	12184		necify Yes or N	United		can Indian,
00	permit. Pages 1 and 2 should be liled within 72 hours after death with the Maryland Important of Health and Mental Hygiene. Important: I flem Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fun	Armed Forces? 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced Armed Forces? 1 □ Yes 2 ★ No If Yes, Give Year or Dates:		Yes, specify Cuba ☐ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	o Rican, etc.)	Bla Specif	ck, White,	
3	atural cal Ex	ed b	15. Decedent's Education	16a. Deced	ent's Usual Occup	ation		16b. Kind of B	usiness/In	dustry
0 1	e. an "na Medic	plet	(Specify only highest grade completed)	(Give I life. D	kind of work done of NOT use retired	during most of wor d)	king			
7	ygiener thanker the	Completed	12	Indus	strial El	lectricia				mpany
מונת	d be fill ental Hy ced oth c even	To Be	17. Father's Name (First, Middle, Last) John Gregg			18. Mother's Nam		e, Maiden Surnar On Joa	,	art
	shoul ind Ma is marl umatl	ř	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street	and Number or Ru	ıral Route Numi	ber, City or Town	State, Zip	Code)
, E	and 2 salth s		Mrs. Carol Gregg, Wife			Route 28	, Valat	ie, New	York	12184
ore	Jes 1 If Item or oth		20a. Method of Disposition 1 ☐ Bunal 2 ☐ Fernation 3 ☐ Removal from State	nce of Dispos metery, cren	sition (Name of natory or other plac		Date	20c. Location		
altimol	tment tant: tant:		4 □ Donation 5 □ Other (Specify) Alban		Cremetory	1		Menands	•	v York
ם Da	permir Depar Impor any Ir		21. Signature of Fungfal Service Licensee M01113	1	. Name and Addre 1 Payne P	ss of Facility W Avenue, C		eral Hon New Yor		037
	5.0		23a. Part1. Enter the disease or complications that caused the death. shock, or heart allure. List only one cause on each line.	Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
F	hysician		Immediate Cause (Final disease or condition resulting in death) a. Idiopathic Due to (fr as a consequence)	Pu	Imonar	y Fibr	osis			Oriset and Death
	/Medical Examiner			ence of):	,	J				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated awards.	ence of):		-	<u> </u>			
k .	ocuted nd transit	Examiner	that illitated events							
Ď.	ricate be executed physician and s the burial-transit	I Ex	Due to (or as a conseque	ence of):						
00/00	physi physi the t	edical	d							
XOD	n certin inding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnan		1=			23d. Da	ate of deliv	ery
0	death	Physician/M	in the past 12 months? 1 Ves 2 No 9 Unknown		Ectopic pregnancy Other <i>(specify)</i>	<i>y</i>		M	onth	Day Year
٦.	at the d by the etach	Phys	9 Li Unknown	Nas is Also	. daylidaa aayaa ah	en in Dod I	ooo Did	tobooo use see	Authorian An A	be served of death?
ecords,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions contributing to death but not result Right Venmonar Failure	-	idenying cause giv	enin Faiti.		Yes 2 No		he cause of death? bably 4 \(\frac{1}{2} \) Unknown
Ö	w req	lete	Pulmonary Hypertension				24a. Wa	s an 24h.	Were auto	opsy findings available
ב ב	The la	Completed	Talmonary Hyperkistori			·	auto	opsy formed? 2 2 No	prior to co death? 1 ☐ Yes	mpletion of cause of 2 No
<u> </u>	stiffice ctor, p	Be C	25. Was case referred to medical examiner?			26. Place of Dea				
5	this co	2	1 Yes 2 No Hospital: 1 Inpatient 2 □ E		t 3 DOA Oth	4 ☐ Nursing H		sidence 6 🗆 Ot		fy)
ב כ	ding F	ion:	1 Natural 5 Pending (Month, Day Year)	28b. Time of Injury	Wor	ryat ′k? Yes 2 ∐ No	28d. Describe	how injury occu	rred	
VISION	Atten death actor:	ficat	3 Suicide 6 Could not be	ne, farm, stre			28f. Location	(Street and Num	ber or Run	al Route Number,
5	tal or s after al Dir	Certification:	4 ☐ Homicide determined building, etc. (Specify)				City or To	own, State)		
	To the hospital or Attending Physician: The lay within 24 hours after death, within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 and 10 hours a	Medical (29a. Certifier (Check only one) 1 Certifying Physiclan: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	rledge, death on and/or in	n occurred at the til vestigation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time	e cause(s) and m e, date and place	anner as s	stated. to the cause(s)
,	within To the	Me	29b. Signature and title of certifier		29c. Licens	e number		29d. Date signe	ed (Month,	Day, Year)
			Muscl mo		P18	1559		June,	11	2007
	dy		30. Name and address of person who completed cause of death (Item:			D 11.				
	,		Meena V Shah MD 22 South G 31. Date filed (Month, Day, Year) 32, Degistrar's Signatu		. Street	Baltin	rore			
	Sta Registr		IIIN 1 Q 2007	. 1						

07-04524 Ma

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

aurice Gordon		State of Maryland / Department of He For State Certificate of De	ealth and Mental Hy eath	/giene Reg. I	200	7 1958
Physician		paistrar Decedent's Name (First, Middle,Last)		Date of Death Month Date		3. Time of Death
ledical Examine	er	Maurice Gordon	To a serious of Double	June 13, 200		0245 hrs
	4	, and the same that the same t	ity, Town, or Location of Death		AC. County of Death	1
Funeral	5	Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Under 1 Year If Under 24Hrs.	8. Date of Birth(Foreign	nplace (State or
Director		2.14-35-65/6 1XM 2 F 15 Yrs. M	onths Days Hours Min.	2/19		intry) MD
and the trade of the trade or the state of	Ţ	sual Residence of Decedent Da. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
t cow an		MI) NA Baltimo	50			1 Yes 2 No
Aaryland 28a-f show any 1 at once.	Director		f. Zip Code	10g.	Citizen of What Cour	itry?
tith the Maryland 23a or 28a-f sho notified at once		2514 Linden Avenue	21217		USA	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene 7 is marked other than "natural", or items 23a or 28a-f she rare even, the Medical Examiner must be notified at once		1. Marital Status 12. Was Decedent Ever in U.S. 13. Was De	ecedent of Hispanic Origin? (Spacetry Cuban, Mexican, Puerto		14. Race - Americ White, etc.	can Indian, Black,
er deat		1 Yes 2 No	s 2 No specify:		Specify: 2	ac.K
urs aft	ᅙ	or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's U	Isual Occupation (Give kind of v	vork done 10	6b. Kind of Business/I	ndustry
6 172 ho	Completed	Flomentary/Secondary (0-12) College (1-4 or 5+)	of working life. DO NOT use reti	red)	NA	1
5-0036 led within 7- tygiene other than the Medica	<u>ا</u>	7. Father's Name (First, Middle, Last)	tudent 18. Mother's Name	(First, Middle, Mai		
21215-0036 old be filed within 72 hours after Mental Hygiene e nearked other than "natural";	Re D	Maricico Gardon-Bev	Jill	ρ.	Jenkin	S
2121 hould be fill hould be fill hould be fill is marked ttic event,	0	9a. Informant's Name/Relationship (Type, Print)	dress (Street and Number or F Linden Avenu	Rural Route Numbe	er, City or Town, State	, Zip Code)
Md 2 alth a 2 mm 2 mm 2 mm 2		13.11 P. Jenkins Mother 2017 Oa. Method of Disposition 120b. Place of Disposition		Date Baltin	20c. Location - City or	Town, State
	- 11	1 Y Burial 2 Cremation 3 Removal from State crematory or other p	olace)	lalat	Baltimon	a MIN
Baltime permit. Pag Department Important: injury or ot		4 Donation 5 Other Spacify: 1. Signature of Funeral Service Licensee / 22. Name	e and Address of Facility	- 14 0	1) q Minici	J 1711
Ball permit Depart Impor injury		Fortelle & Harris L.Th. azz	seph L. Russ	venue.	Ba Himore,	
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the manufailure. List only one cause on each line.	node of dying, such as cardiac c	or respiratory arrest	t, shock, or heart	Approximate Interval Between Onset and Death
Examiner	1	mmediate Cause (Final disease or condition resulting in death) a Multiple Gunshot Wounds Due to (or as a consequence of):				Death
		Sequentially list conditions, b.				
		f any, leading to immediate Due to (or as a consequence of):				
sit sit	Хай	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
	edical	d. UNPENDED AMENDED		···-		
60, ate be ex hysician e burial	틯	F FEMALE: 23c. If yes, outcome of pregnancy		-	23d. Date of deliver	y
687 certific ading p	jan'	3b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal of Pregnant at time of death 5 Other		ancy	Month	Day Year
Box 6876(ne death certificate the attending physelet for use as the b	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown	(Specify)			
P.O. I es that the igned by the detache	by P	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.		acco use contribute to 2 ✓ No 3 Pro	
ords, P w requires t s been sign should be c	ed			24a. Was ar		utopsy findings available
cord	Completed			autopsy perform	y prior to ned? death?	completion of cause of
tal Rection: The certificate		25. Was case referred to medical	26.Place of Death (Check	1 Yes 2	No 1 Y	es 2 No
Vital Rec	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3	DOA Other Nursi	ng Home 5 R	Residence 6 Othe	er:
n of \ding Phys. After the funeral	١	27. Manner of Death 28a. Date of Injury 28b. Time of Injury CMRRth, Day, Year)		28d. Describe ho Subject shot	ow injury occurred	
vision or Attendi	턡	2 Accident Investigation , hrs	1 Yes 2 V No	28f Location (St	reet and Number or R	ural Route Number, City
Division of Vital Records, tal or Attending Physician: The law requir is after death. The law required in the first certificate has been sized in by the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director.	Certification:	3 Suicide 6 Could not be determined (Specify) Local Street	ractory, office building, etc.		ate) venue, Baltimore , I	
hou hou		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred	d at the time, date and place, an	d due to the cause	(s) and manner as sta	ted.
Fo the vithin Somple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.		at the time, date a		
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Mo	onuri, Day, rear)
,\ \	ļ	30. Name and address of person who completed cause of death (Item 23a)				
M		Carol Allan, MD Assistant Medical Examiner 111 Penn Str	reet, Baltimore, MD 212	01		
Sta		31. Date filed (Month, Poly Year). 32. Registràr's Signature	ell)			
Registr DHMH 17 Rev 1/20		ORIGINAL	age.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 6:18 PM Lillian Constance Gregory SUNG 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BOR 405 PITAL CENTER if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number Hours **Funeral** Months Davs 83 1 □ M 2 😾 F Maryland 20, 192B Sept. Director 218-12-4230 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 No North Linthicum Anne Arundel Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or 7 U.S.A. 21090 315 Hance Avenue permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must boonce. Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11 Marital Status Specify: white 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🗷 No Baltimore, Maryland 21215-0036 þ 3 Nidowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be R. Lillian Provance Clarence Richardson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 832 Cedar Drive Deale, Maryland 20751 Sandra Taylor/Daughter 20b. Place of Disposition (Name of cametery, crematory of other place)
Meadowridge Memorial
Park 20c. Location - City or Town, State Date 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 06-22-2007 Elkridge, Maryland 4 Donation 5 ☐ Other (Specify) Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 21. Signature of Funeral Ser Licenses 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) immediat ardiac dysrhythmia **Physician** /Medical Due to (or as a consequence of): Examiner immediate Myocardia if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician; The law requires that the death certificate be executed Oronary burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1□Live birth 2 Fetal death 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a detached f 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 CER/Outpatient 3 DOA 1 Inpatient 1 Hes 2 No Certification: To After this 28d. Describe how injury occurred 28a. Date of Injury 28h Time of 28c. Injury at Work? 27. Manner of Death (Month, Day Year) 5 Pending investigation 1 Natural 1 ∏Yes 2 ∏No death. 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

michelle Gossman

JUN 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32. Paristrar's Signature

DHMH 17 Rev 1/200

ORIGINAL

29c. License number

D0062693

3001 S. Hanover Street Baltimore, MO

29d. Date signed (Month, Day, Year)

07-04563 Jerry Green

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death

)	n	1	7	1	13	6	0	
-	U	1.7	1		1	U	U	1 - 4

		For State			Certific	ate of	Death					Reg. No.		
Physicia		Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year									Year	3. Time of Death		
al Examin		Jerry			Gre	en					June 14,	2007		2100 hrs
	4	la. Facility Name (if not instituti	ion, give street and i	number)		41	b. City, Tov		cation of I	Death			nty of Deat	th
		Union Memorial Hosp	pital				Baltimo	re					NA	
Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last bir	thday)	If Under		If Under	_	8. Date of E	Birth (MM/DD/Y	YYY) 9. Bi Forei	irthplace (State or ion
Director		212 00 7210	1X M 2 F		45	Yrs.	Months	Days	Hours	Min.	10-1	5-1961		ountry) Md.
	ŀ	212-88-7219 Usual Residence of Decedent	'A_'W '-		_45									
any	1 0 1/2 1	10a. State 10b. County	у	100	. City, Town	or Location	on							10d. Inside City Limits
* .	- 1	Md.	NA		Ba	ltim	ore							1 X Yes 2 No
Maryland 28a-f show d at once.	후	10e. Street and Number	147.1				10f. Zip C	ode				10g. Citizen o	f What Co	untry?
th the Maryland 23a or 28a-f sho	Director											,	103	
3a or		1641 Carswel						1218		0/0-	-16 - W		JSA	erican Indian, Black,
ms 2	era	11. Marital Status	A	Forces?	er in U.S.		s Decedent es, specify				cify Yes or lican, etc.)		White, etc.	Silcari indian, Didox,
death or ite	Funeral	A	1 Yes	2 X	No			_				0	- W = 7	•
after	by F		Divorced If Yes, Give or Dates:				Yes 2X					16b. Kind	cify: Bla	
5-0036 led within 72 hours a Hygiene. t other than "natury the 'M dical Examin	٩	15. Decedent's Education (Sp	pecify only highest g	rade comple	ted) 16a.	. Decedent during me	t's Usual O ost of worki	ccupatic ng life. [on (Give ki DO NOT u	na ot wo se retire	rk done d)	160. Kind	Ji Dusilles:	silidustry
72 h	leted	Elementary/Secondary (0-12	2) College	(1-4 or 5+)										. •
r than	dwo	10th grade				Vari	ous					COI	nstru	ction
5-0036 iled within 77 Hygiene. I other than the Medical	3	17. Father's Name (First, Middl	le, Last)		_			1	8.Mother's Ja	name (First, Middl	e, Maiden Sum	_{name)} Gilva	2017
21215-003 ould be filed within i Mental Hygiene. s marked other th ic event, the Medi	Be	Thenell			Green			- 1	- Jan	100	_	1100	griva	_
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Iant: If item 27 is marked other than "natural", or items 23a or 28a-fish or other traumatic event, the "K-dical Examiner must be notified at once	유	19a. Informant's Name/Relation				9b. Mailing	Address	(Street	and Numb	er or Ru	ıral Route N	Number, City or	NA Sta	21234
ore, MD 2 es 1 and 2 shou of Health and N If item 27 is n her traumatic		Janice G. Fra	ncis	Siste								imore,		or Town, State
e, l and l Aleal Heal		20a. Method of Disposition	Dames of	d from Ctoto		e of Dispos atory or oth	ition (Name her place)	e of cem	etery,		Date	200. 2002	tion - Oity	or rown, state
10r ages mt of nt: If		1 X Burial 2 Cremati		ii irom State		ity C				6-2	21-07	Dune	dalk,	Md.
Baltimore, permit. Pages I an Department of Hea Important: If iter	ŀ	4 Donation 5 Other 21. Signature of Funeral Service			<u> </u>	22. N	Name and A			Ma	arch E	H. Ea	st	
Ba Perm Depi		& Qual	a Wa	سا	<u> </u>					Ave.	., Bal	ltimore	, Md.	21202
hysician		23a. Part I. Enter the disease,	or complications the	at caused the	e death. Do	not enter t	he mode of	dying, s	such as ca	rdiac or	respiratory	arrest, shock,	or heart	Approximate Interval Between Onset and
/Medical		failure. List only one cau	Cocci	ne into	vicatio	ND.								Death
Examiner		Immediate Cause (Final disea or condition resulting in death		as a consequ		M1								
		O Not the transference	b.											
	ē	Sequentially list conditions, if any, leading to immediate		as a consequ	ence of):									1
	aminer	cause. Enter Underlying Cause (Disease or injury that initiated	d ⁽⁾ .											
bd Isit	Exa	events resulting in death) Las	31	as a consequ	ience or):									
760, Trate be executed s physician and the burial - transit			d	#18	perli,	G869,7	//16/07	,WS						
नंबा ६	/Medical	X UNPENDED	X AMENDE	,PII,27	,28a-f,	perM	E. g868	3. 6/	20/07	TT_{-}		1024 0	ate of deliv	
760, Ticate be g physic the bur	/Me	IF FEMALE: 23b. Was decedent pregnant in	23c. If y	es, outcome	of pregnance	CV					ncv	E .	onth	Day Year
68 certif ding	ian	past 12 months?		regnant at tir	ne of death		ther (Spec				,			
Box 687 he death certiff the attending	sic	1 Yes 2 No 9	t laboration	nknown		0 0	(ilei (opoc	,				_		7
the d	Ph)	Part II. Other significant con	aditions contribution	ng to death t	out not result	ting in the	underlying	cause g	jiven in Pa	rt I.				to the cause of death?
P.O.	by	Hypertensive									1	Yes 2 N	lo 3 F	Probably 4 🗸 Unknown
S, quire en sig	ted											Vas an	24b. Were	autopsy findings availab
Orc tw retas be	ple											utopsy erformed?	prior death	
Che la	Completed by Physiciar										1Y	es 2 ✔ No	1	Yes 2 No
an: 1 an: 1 entific	O	25. Was case referred to med							of Death	-	-			
Vita ysicia his co direc	o B	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient	2 🗸 ER	VOutpatier		OA	Other ₄		g Home 5			ther:
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rate death. "In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	=	27. Manner of Death	28a. [Date of Injury Month, Day, Yea		b. Time of	Injury		ry at Work		_	ribe how injury	occurred	
on endin ath. or: A	Ę.		Pending 6/	14/2007	F	nd 8:3	30 pm		Yes 2 X		unk			
iSi rAtto er de irecto n by t	fica	. T	nvestigation 28e.	Place of Inju	ry - At home	e, farm, stre	eet, factory	, office b	ouilding, e	tc.		ion (Street and wn, State)	Number o	r Rural Route Number, Ci
Div talo rs aff	Certification:	3 Suicide 6 A C	determined (Spe	cify)	resid	lence					1641	Carswell	St. B	altimore, MD_
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. When Funeral Directors. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Ö	29a. Certifier	g Physician: To the	e best of my	knowledge,	death occi	urred at the	e time, d	ate and pla	ace, and	due to the	cause(s) and r	nanner as	stated.
the I hin 2 the I	Medical	one) 2 Medical I	Examiner: On the ba	asis of exam ner stated.	ination and/	or investig	ation, in my	y opinior	n, death o	ccurred a	at the time,	date and place	, and due t	to the cause(s)
To To Con	Me Me	29b. Signature and title of ce		ilei stateu.			29	c. Licens	se number			29d. Da	te signed	(Month, Day, Year)
	1	(Val 1. 1	x 110	0 0 0	a D			O.C.	M.E.			June	15, 200	7
T		30. Name and address of per	TO ITO	cause of do	ath (Item 22	la)								
0			Assistant Medi			11 Penn	Street,	Baltim	ore, MD	2120)1			
				-	s Signature									
Regis	State Strai		9 2007	Below	, K	Agos	de							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** UNE 2007 Corrine A. Green /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMURE
If Under 1 Year If Under 24 Hrs. HENES 5. Social Security Number 8. Date of Birth 10-21-1925 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 81 Yrs. 220-18-8707 Usual Residence of Decedent MD Director e filed within 72 hours after death with the Maryland al Hygiene.
other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location . State MD 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director n/a Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3645 Gelston Drive 21229 Funeral USA 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: African-Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced American
16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Security Receptionist Admin. 18. Mother's Name (First, Middle, Maiden Surname . Pages 1 and 2 should be filk timent of Health and Mental Hitant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) unk Be Maggie Jackson ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela Goddard/ Cousin β647 Gelston Drive, <u>Balto. MD 21229</u> 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If its any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/18/07 |Balto. MD 22. Name and Address of Facility $Wylie\ F/H\ P.A.$ of Balto. 21. Signature of Funeral Service Licenses andon 9200 Liberty Rd., Randallstown, MD 21133 3a. Part1. Enter the disease, or complications that caused, e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPHYXIATION Physician 30 MINUTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ASPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and Due to (or as a consequence of) aftending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed 2. No Division or Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury PM 1 Natural 5 Pending investigation 2 Accident
3 Suicide 8 1 ☐ Yes 2√2 No ours after death.

neral Director: A
filled in by the fu U1812007 Subject Choxed on Food.

28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide BU47 Gelston Dr. Baltimore, MD within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier D0051865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPIM BALAMORE MI MARIES CURTIS 57

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JUN 1 9

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death P Dav MARIA GREEN HILL 6:30 2002 5 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BON SECOUNG HOUPITAL BALTINOZE n/a MD 2175 9. Birthplace (State or Foreign Country) VA 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 ☐ M 2 💢 F 80 212-34-8064 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐Yes 2 ☐ No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2436 Edmondson Avenue 21223 USA 14 Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📈 No African-Specify: Specify. 3 Widowed 4 □ Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cosmetologist Self-Employed 10th18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George H. Jackson Florence S. Hurt 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Florence Sheila Mason 1031 Cooks Lane, Balto.MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) Greenview Cemet. 6-26-07 | Blackstone, VA 21. Sign 🕶 Funeral Service Licensee 22. Name and Address of Facility Wylie F/H P.A. of Balto.Co 9200 Liberty Rd., Randallstown, Approximate Interval Between Orset and Death 2 a. Part1. Enter the disease, or complications that caused the de. h. shock, or heart failure. List only one cruse on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 mon Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 20 1 ___ inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Director

Funeral

þ

Completed

Be

2

Examiner

Physician/Medical

<u>^</u>

Completed

Be

Certification: To

27. Manner of Death

2 ☐ Accident

3 ☐ Suicide

5 ☐ Pending investigation

6 ☐ Could not be

filed within 72 hours after death with the Maryland

1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than

other traumatic event.

unit of Health ar.

vnt: if item 27 is m.

y or other

permit. Page Department o important: if any injury or

Pages 1

Maryland 21215-0036

3altimore,

burial-tran physician the as asn Por been signed by the should be detached page 2 has certificate

requires that the death certificate be executed Physician: this After the funeral or Attending within 24 hours after co...

To the Funeral Director: Aft

Division or Vital Records, P.O. Box 68760,大

State Registrar

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies Year) 31. Date filed (Me 2007

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28b. Time of

Injury

28a. Date of Injury (Month, Day Year)

07-04600 Alvis Harris Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

IVIS MAITIS		State of Maryland / Department of Health and Mental Hy - For State Certificate of Death		200	1 1
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	Reg. 2. Date of Death	No.	3. Time of Death
ledical Exami		Alvis Harris	Month E June 16, 20	Day Year 07	1334 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
		University Hospital Baltimore	To Day (Did		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.		(MM/DD/YYYY) 9. Birt	n
Director	-	217-91-9946 1XM 2F 40 Yrs.	June 25	0.1966	untry) MD
gg grant of the state of the st	~	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
* "	اڃ	MD Baltimore			1 Yes 2 No
Maryland 28a-f show 1 at once.	rector	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Cour	ntry?
with the Maryland ms 23a or 28a-f she be notified at once	ਙ	1200 Cherry Hill Moad 2/225		U.S.A	
th wit ems 2 t be n	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 1f Yes, specify Cuban, Mexican, Puerto		14. Race - Ameri White, etc.	can Indian, Black,
er dea		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: B)	ack
2 hours afte "natural", Examiner	g	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of v		6b. Kind of Business/I	
5 72 ho in "na	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	red)	11	
0036 within 72 iene. er than Medical	Ę.	9th Barquet Coordinator		Hotel	
filed in Hyging of oth	ပ	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Ma	iden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F	Rural Route Numb	er, City or Town, State	, Zip Code)
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other tranmatic event, the Medical Examiner must be notified at once	-	Deborah Gray / Sister 4509 honoymeade	The Own	nas mills i	mp 21117
re, I I and Theal	Ī	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
Baltimore, Department of Hee Important: If ite		4 Donation 5 Other Specify: Green many	22.07	Baltimor	e.MD
Balti permit Departin Imports injury o		21. Signature of Funeral Service Licensee	5	rune funera	_
		Vauyun C. Creen 8728Liberty Ind. 23a. Part l'Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o		UStain N	Approximate Interval
Physician Wedical	I	failure. List only one cause on each line.	respiratory arres	t, shock, or fleat	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) Blunt Force Injuries to the Head Due to (or as a consequence of):			300
		Sequentially list conditions, b.			
	Examiner	if any, leading to immediate oute. Enter Underlying Couce C. Observed the Underlying Couce C.			
_ =	xam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
and and trans		d			
60, ate be ex hysician e burial	Medical	UNPENDED			
Box 68760, to death certificate be executed the attending physician and od for use as the burial - transition of for use as the burial - transition of the second of the s		IF FEMALE: 23b. Was deedent pregnant in the 2 Fetal death 3 Ectopic pregnancy	ancy	23d. Date of deliver	y Day Y ear
Box 687 death certific the attending p	icia	4 Pregnant at time of death 5 Other (Specify)			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did tob	acco use contribute to	the cause of death?
ires that the signed by the detache	þ	Tatti. Other significant conditions		2 ✓ No 3 Prol	
cords, aw require nas been si 2 should b	Completed		24a. Was ar		itopsy findings available
c law 1 e las b e las b	ğ		autopsy	ned? death?	completion of cause of
Division of Vital Records, rial or Attending Physician: The law requir rs after death. al Director: After this certificate has been sted in by the funeral director, page 2 should!		25. Was case referred to medical 26.Place of Death (Check	1 Yes 2	No 1 ✓ Yo	es 2 No
Vita hysician this cer	o Be	examiner?	-	esidence 6 Othe	r:
n of Jing Ph After th funeral	\vdash	27. Manner of Death 28a. Date of Injury (Morth, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe ho Subject beate	ow injury occurred	
ion ttendi death. tor: /	aţio	1 Natural 5 Pending Jun 16, 2007 on 100 hrs 1 Yes 2 ✔ No	Subject beate		
lor A after of Direct	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town, Sta	ite)	ural Route Number, City
ospita hours nueral		4 Homicide (Specify) Parking Lot 29a. Certifier Continue Physician: To the best of my knowledge death occurred at the time date and place and		Road, Baltimore, N	
Division To the Hospital or Attency within 24 hours after death To the Funeral Director:	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a			
To COIT	Mec	29b. Signature and little of certifier 29c. License number		29d. Date signed (Mo	nth, Day, Year)
		O.C.M.E.		June 17, 2007	
3		30. Name and address of person who completed cause of death (Item 23a)			
2		Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21	201		
St Regis	ate	31. Date filed (Month, Day, Year) 32. Jegistrar's Signature			
DHMH 17 Rev 1/2		ORIGINAL			
2000 17 NOV 1/2	501	UNIGNAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State of Maryland	•	irtment of H tificate of L			ene 007	19683
ı	Physicia	an	1. Decedent's Name (First, Middle, Last) Joan Frances Houston				June 16,2	2887 Yea	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c. County of De	ath
			The House Of Jubilee 5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthdav)	If Under 1 Year	Iston If Under 24 Hrs	8. Date of Birth	Harf	irthplace (State or Foreign
	Funeral Director		216-28-7554 1 M 2 1 85	Yrs.	Months Days	Hours Min	8. Date of Birth (Month Day)	921 Can	iff, wales
	pu .		Usual Residence of Decedent 10a, State 10b, County 10c, City,	. Town or Lo	cation				10d. Inside City Limits
	Maryla (sho	or	MD Harford		st Hill				1 ☐ Yes 2 No
	or 28a	irec	10e. Street and Number		10f. Zip Code		10	g. Citizen of What	Country?
	ath wit	ralD	2603 Putnam Road			050		USA	- siene Indian
	ltema Itema	Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Ves 2 □ No				Specify Yes or No- rto Rican, etc.)	Black, W	
2-003p	al', or	þ	3 ⅓ Widowed 4 □ Divorced Year or Dates:		1□ Yes 2 No	Specify:		Specify:	White
ဂ ဂ	72 ho 'netur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of w	orking	6b. Kind of Busines	
7	within ene. then '	Juno	Elementary/Secondary (0-12) College (1-4or 5+)	Ex	ecutive	Secret	cary	Rheems	5
ם ע	a filed I Hygi other	Be Co	17. Father's Name (First, Middle, Last)				me (First, Middle, M		
yland	Menta Menta arked atic ev	2	William Morgan				ne E. To		
Mar	id 2 sho lth and 27 is m		Janice Houston-daughterwin	19b. Mailir 260	ng Address <i>(Street a</i> 3 Putnar	and Number or F N Road-	Rural Route Number, -Forest H	City or Town, State Hill, MD	21050
nore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "netural", or Items 23e or 28a-f show any injury or other treumatic event, its Modreal Exam har must be notified at Once.		20a. Method of Disposition 1 □ Burial 2 Oremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify)	ace of Dispo	sition (Name of Pater of the place Bel Air	(e) 6-1		Oc. Location - City Forest I	
Baitimor	permit. F Departme Importer any injur		21. Signature of Funeral Service Licensee	22 E)	Name and Address VANS FUI ND CREMA	ss of Facility	CHAPEL SERVICES	Newport Fores	Drive Hijve 21050
r			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	, , , , ,				st,	Approximate Interval Between
	Pnysician	4)	Immediate Cause (Final disease or condition Repair	si.					Onset and Death Weeks
	/Medical Examiner		resulting in death) Due to (or as a consequ						37
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequ		~				7 22-3
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
Ď,	e exec ian an urial-ti	Exa	resulting in death) Last . Due to (or as a consequ	ience of):					
09/8	certificate be executed nding physician and use as the burial-transil	dlcal	d						
Rox 6	leath certific attending pl	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregna					23d. Date of	,
	law requires that the death as been signed by the atter 2 should be detached for u	Physician/Me	205. Was decement pregnant in the past 12 mopths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Dectopic pregnancy Other (specify)			Month	Day Y <i>e</i> ar
0	quires that the der n signed by the a lid be detached f		Part II. Other significant conditions contributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute	a to the cause of death?
ecords,	uires n sign	d by	ASCUO IDAM				1 ☐ Yes	s 2 2 √ √0 3 □	Probably 4 Unknown
O O O	law requas been 2 shoul	Completed	m= 0.115				24a. Was an		autopsy findings available to completion of cause of
¥	The ate h page	Com	Cura a la maria				perform 1 Yes 2	ed? death	i? ′es 2□ No
Vital R	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital:		- Cth		eath (Check only one		n ssisted
ō	Phys this al di	. To	1 Yes 2 10 1 Inpatient 2 27. Manner of Death 28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injur	y at	Home 5 Resider		pecity) /1073
lon	ttending I death. ctor: After y the funer	atlor	2 Accident investigation	Injury	Wor M 1 □	Yes 2 □ No			
Division	or Attendater death Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At ho building, etc. (Specify	ome, farm, st	reet, factory, office		28f. Location (Str. City or Town,		Rural Route Number,
	spitel		29a. Certifier 1 Certifying Physician: To the best of my known	wiedge, deat	h occurred at the tir	me, date and pla	ce, and due to the ca	use(s) and manner	as stated.
	To the Hospital or A within 24 hours after To the Funeral Direction plately filled in by	ledical	(Check only one) 2 Medicel Examiner: On the basis of examination and manner stated.	tion and/or in					
		Σ	29b. Signature and title of certifier		29c. Licens		29	ed. Date signed (M	
	7		30. Name and address of person who completed cause of death (Item	23a) (Time	Print)				
	10		Wendy Klupse mo 4701 11	Che-le	St Si	T 4202	70 wson	md :	21264
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signa JUN 1 9 2007	ture	•				
	Regist	rar	JUN 1 9 2007 Marine S	600	West of the second				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 868 6-25-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Mary Hennigan Month **Physician** 13 06 07 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Good Samaritan Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Year) Months Days Hours 1□M 2₩F Yrs. 93 2/20/1914 Ireland 170-09-4214 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County or items 23a or 28a-f shov aminer must be notified at 28a-f show 1 Yes 2 No Directo Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 21234 USA 7107 Chambers Road Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. event, the Medical Examiner Pages 1 and 2 should be filed within 72 hours after on the file of Health and Mental Hygiene. 1 Tyes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Baltimore, Maryland 21215-0036 Specify: Completed by White 3 Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) if Health and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Sun Paper Checker 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jordon Bridget Α. Martin Fahey other traumatic 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Chatsworth Court Fallston, Md. 21047 Mrs. Sharon M Rebbel/Daughter 1702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot Marial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Moreland Mem. Park _6/16/07 Baltimore, Maryland 21. Signatur Fun al Service Li 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md 21204 flications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a ☐Yes a☐No 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 4 Unknown 1 🗌 Yes 2 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed s certificate has to irector, page 2 st 1□ Yes →2□ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After Injury 5 Pending investigation **1** Natural n 24 hours after death.

In Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide +Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier h who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 32. Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

OBIGINAL

			For State Registrar	State of M	arylan		artment of l <i>tificate of</i>		nd M	ental I		ene j. No. 2 (1117	Andrews &	158
14	SUL!		1. Decedent's Name (First, Middle, Last)							2. Date of Month	Death	Day	Vasu	3. Time	of Death
60	Physici: /Medic		William F. H	Herrmann,	, Jr.					June	14,	2007	Year	6:41	m M
	Examin		4a. Facility Name (If not institution, give s	treet and number))		4b. City, Town,	or Location of	Death			4c. County	of Death		1
			Gilchrist Center				Towson					Balt	imor	е	
E	Funeral Director	6	5. Social Security Number 6. Sex 365–18–5621	M 00 F	ge (<i>In yr</i> s. 9 1	last birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of (Month) Dec.	, Day, Y	^(ear) 1915	Cour	olace (State otry) higan	e or Foreign
	p ,		Usual Residence of Decedent 10a. State 10b. County		100 Cit	y, Town or Lo	cation						Τ.	Od Incido	City Limite
	laryla shov ed at	'n								10d. Inside City Limits 1 ☐ Yes 2 ☐ No					
	the N 28a-f sotifie	Directo	Maryland Baltimore	3	Pa:	rkvill	10f. Zip Code				100	g. Citizen of \	Mhat Cour		X
	with a or	Ö	8820 Walther Blvd	4 #31.17			21234				1.00			, .	
	ns 2%	Funeral		2. Was Decedent		.S. 13. V	Was Decedent of f Yes, specify Cul	Hispanic Orig	jin? (Spe	cify Yes o	r No-	USA 14. Rac	e - Americ	an Indian,	
(0	ifter or iter	교	1 ☐ Never Married 2 ☐ X Married	Armed Forces' 1 ☐ Yes 2 If Yes, Give					, Puerto I	Rican, etc.)		k, White,	etc.	
8	ours a ral", o Exam	by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			1□Yes 2□XNo	Specify:				Specify	"Whi	te	
215-0036	within 72 hours after death with the Maryland ene. than "natural" or items 23a or 28a-f show he Medical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)		(Give	tent's Usual Occu	durina most	of workii	ng	16	6b. Kind of B	usiness/In	dustry	
7	ithin ne. han "	ď	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT use retire				_			_	
2	2 should be filed w n and Mental Hygie is marked other ti raumatic event, th		17. Father's Name (First, Middle, Last)	4		Mechai	nical En	T	r'e Namo	(First Mic		dgewoo		senal	
auc	ntal he fi	Be			2								_		
Maryland	hould Me Id Me mark matic	은	19a. Informant's Name/Relationship (Typ	rrmann, S	Tr. •	19b. Mailir	ng Address (Stree		arga rorBura		P.			Code)	
ĕ	nd 2 s lth ar 27 is 27 is trau		Elsie M. Herrmann			1	Walther					•			
<u>6</u>	f Hear tem		20a. Method of Disposition	WI10	20b. F	Place of Dispo	sition (Name of natory or other pla	1		ate	_	Oc. Location -			
9 E	Page: ent o nt: if i		1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	.	-	Jallev C	· i	ine 1	16 20	o t	imoniu	m. Ma	arvla	nď
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or thems 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Puneral Service License				2. Name and Addr			20,20	<u> </u>			ork R	
m	Pe in Pe			RAM		Ru	uck Tows	on Fune	eral	Home	, I	nc. To	wson	.Md.2	1204
9			23a. Part1. Enter the disease or complications, or heart failure. List only on	s that cause use on each I	d the deat	h. Do not ent	er the mode of dy	ing, such as o	cardiac o	r respirato	ry arres	st,	W. Second	Approxim	ate Setween
	Physician		Immediate Cause (Final disease or condition	æ	cuit	e a	Wonk	my 1	AVI	Luy	2	rsida	me	Onset an	
	/Medical		resulting in death)	Due to (or as	s a conseq	uence of):	AVI	, 10,	1.	1		-		2 / 3	1
	Examiner		Sequentially list conditions,	_ 4	NS	1 pry	AV	lery	Q (501	31			46	ears
E)	si ed	ine	if any, leading to immediate cause. Enter Underlying	Due to (or as	s a conseq	uence of):		ŕ						/	
1	xecul and al-trar	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	s a conseq	uence of):							-		
68760, P	icate be executed physician and s the burial-transit	<u>100</u>		,	,										
		edical	0									-			
ŏ	anding use a	2	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome			7e-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1					23d. Da	te of deliv	ery	
Division or Vital Records, P.O. Box	The law requires that the death certificate has been signed by the attending spage 2 should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant a 9□Unknown			Ectopic pregnan Other (specify)	cy			_	Mo	onth	Day	Year
0	at the by th	hys	9 ☐ Unknown												
Ś	es th igned be de	by F	Part II. Other significant conditions con	tributing to death I	but not res	ulting in the u	nderlying cause g	iven in Part I.				cco use conf			
oro	w require been signature should b	ted									I ∐ Yes	2 □ No	3 ∐ Proi	Dably 4	Unknown
ခ္တ	e 2 st	Completed									Vas an autopsy		prior to co	psy finding mpletion o	s available f cause of
E	r. The lav cate has	Co								1 V	erforme es 2[No	death? 1 🗌 Yes	2 No	
Ħ N	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	ospital:				26. Place						11	
ō	Phys r this ral dii	. To	1 Yes 2 No	1 ☐ Inpat		ER/Outpatier 28b. Time o	IL 3 DOA	4 ∐ Nur				ce 6 10th		(y) / C	spice
on	iding Phy h. After thi funeral (tion	1 ☑ Natural 5 ☐ Pending investigation	(Month, D		Injury	W	ork?]Yes 2.∐N				,,			•
<u> S </u>	Atter r deal ector by the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of in	jury - At he	ome, farm, str	eet, factory, office)	1	28f. Locati	on (Stre	et and Numb	er or Rur	al Route N	umber,
	tai or s afte si Dir	Certification:	4 ☐ Homicide determined	bullaing, e	tc. (Specif	<i>y)</i>				UITY O	Town,	Siale)			
	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifics completely filled in by the funeral director; r	edical (29a. Certifier 1 Certifying Phys	iclan: To the besi	t of my kno	wledge, deat	h occurred at the vestigation, in my	time, date and	d place,	and due to	the cau	use(s) and mate	anner as s	tated.	e(s)
	the I	Medi	one) 29b. Signature and title of certifier	and manner s				ise number				d. Date signe			
	Vait To		250. Signature and title of certifier	10.	wo		1) 2.	5 1011 5 101			7	. Jac signe	5° >	On Z	/
	1		2/1 1/2 / huy 1	malata	dogsh //s-	n (19a) /T	Print)				1		_/_		
	6		30. Name and address of person who co W.A. R. Ley G.	364 (6)	death (Iten	N. Chu	wes (L. Ba	lto	Md	2	206			
	Sta	to	31. Date filed (Month, Day, Year)	32. Regist	trar's Signa	ature									

DHMH 17 Rev 1/2001

State Registrar 07-04568 Kevin David Hunt

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

0	0				-11	
4	U	1	1	2	7)

		For State	Certific	cate of Death	Reg. No.
Physicia I Examin	n/ 1	egistrar . Decedent's Name (First, Middle, KEULN OA	Last) VIO HUNT		2. Date of Death Month Day Year June 15, 2007 3. Time of Death 0700 hrs
	4	a. Facility Name (if not institution, 6117 Oakland Mills Roa		4b. City, Town, or Location of Dea Sykesville	Carroll
Funeral Director		214 80 0788	7. Age (In yrs. last bir		Irs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) M.D.
d how any		Jsual Residence of Decedent Oa. State 10b. County A	2ROLL SY	n or Location KESVILLE	10d. Inside City Limits 1 Yes 2 No
ne Maryland or 28a-f show	Director	Oe. Street and Number	LAND MILLS RO	10f. Zip Code	10g. Citizen of What Country?
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland in of Health and Mental Hygiene. it: If item 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at once,		11. Marital Status 1 Never Married 2 Mar	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- orto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: WHITE
72 hours afte n "natural"	leted by	15. Decedent's Education (Speci Elementary/Secondary (0-12)	for Dates: Ify only highest grade completed) College (1-4 or 5+)	a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use	LOIEDERMAN/
21215-0036 mid be filed within 72 hours after Mental Flygiene. marked other than "natural", e event, the Medical Examiner.	Be Completed	12. Father's Name (First, Middle, I	Last)	LIN	ame (First, Middle, Maiden Surname) Oa Pulliam
MD 2121 d 2 should be f Ith and Mental n 27 is marked aumatic event,	٢	19a. Informant's Name/Relationsh MICHELE H	ONT /WIFE		or Rural Route Number, City or Town, State, Zip Code) 21789 MILLS ROCK SYKOSIILE MD Date 20c. Location - City or Town, State
		4 Donation 5 Other Sp	3 Removal from State crem	POLL CREMATION THE	6/18/2007 HAMPSTEAD, And
Balti permit. Departe Import	-	28g. Part Pinter the disease, or	complications that caused the death. Do	not enter the mode of dying, such as cardi	Approximate Interval Between Onset and Death
Medical Examiner		Immediate Cause (Final disease or condition resulting in death)			Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	b. Due to (or as a consequence of): c. Due to (or as a consequence of):		
760, cate be executed physician and he burial - transit	Medical Exa	events resulting in death) Last X UNPENDED		.7,28a-f, perME,g881 g869,7/19/07 TT	7/7/08 TT
Box 68760, e death certificate be exthe attending physician ed for use as the burial		IF FEMALE: 23b. Was decedent pregnant in tr past 12 months?	23c. If yes, outcome of pregnan Live birth Pregnant at time of death	2 Fetal death 3 Ectopic pr	23d. Date of delivery
D. BO) t the death by the att	Physi		known 9 Unknown cions contributing to death but not resu	ulting in the underlying cause given in Part I	. 23e. Did tobacco use contribute to the cause of death?
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as t	ompleted by	Alcohol and	l cocaine use, cardio	omegaly	1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy findings availab prior to completion of cause of
of Vital Records, ng Physician: The law requir Nher this certificate has been s nneral director, page 2 should I	Comp			26.Place of Death (CI	performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
/ital sician: is certif	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Inter-rest	10th and	dursing Home 5 Residence 6 ✔ Other: Scene
on of V ending Phy ath. or: After th	tion: To	27. Manner of Death	ding Fnd 6/15/07 F	8b. Time of Injury 28c. Injury at Work? Nd 6:30 am 1 Yes 2 N	
Division spital or Attenditions after death. reral Director: /	Certification:	3 Suicide 6 X Cou	ald not be armined 28e. Place of Injury - At hom (Specify) House	ne, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, Ci or Town, State) 6117 Oakland Mills Sykesville, MD
o the Hos thin 24 h	Medical	29a. Certifier 1 Certifying F one) 2 Medical Example Control Certifying F	Physician: To the best of my knowledge, aminer:On the basis of examination and and manner stated.	d/or investigation, in my opinion, death occu	e, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)
E WE S	Me	29b. Signature and title of certification of the signature of the signatur	me Youle	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) June 16, 2007
OT		Margarita Korell MD.			MD 21201
Regi	State stra		32. Registra's Signature	& South	AAAP .
DHMH 17 Rev 1		3011 1	-à Foot le le le le le le le le le le le le le	ORIGINAL	OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death VIOLET EARLE HESSEY Physician /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore-Washington Medical Center 8. Date of Birth (Month, Day, Ye July 24, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year Days Hours Min 1 □ M 2¥□ F Maryland 214-20-4123 80 1926 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Glen Burnie Maryland | Anne Arundel Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 IISA 309 Milton Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: White Specify Completed by 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) McCormick Spice Co. of Health and Mental Hygiene, item 27 is marked other than other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) 9 Assembly Line Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Thomas Ida Harvey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Diana Rhodes (Daughter) 309 Milton Ave., Glen Burnie, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Important: If its any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 6/20/07 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Balto., Md. 21225-1856 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy o in the past 12 months? 1☐ Yes 2☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No death? 1 ☐ Yes 2 No Vital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Division or After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-Datural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital 24 hours a 🔐 🚅 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18000 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 7 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month 8:10 P **Physician** June 13 2007 Harrison, Jr. Alfred /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ome Millersville Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Anne Arundel

9. Birthplace (State or Foreign Country) Knollwood Manor Nursing Home Social Security Number 6. Sex 7. Age (In Date of Birth (Month, Day, Year) Social Security Number Months Days **Funeral** Hours Yrs. 63 Dec. 10,1943 Maryland 212-42-1531 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Example. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Director Maryland Carroll Westminster 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 4 West George Street 21157 Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 DNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 N Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 N/A Carpenter Contracting Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tressie Harrison, Sr. ဥ Alfred 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 752 225th Street Pasadena, Maryland 21122

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, Street Pasadena, Maryland 21122 Tessy A. Harrison (Daughter) 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 06/15/07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ATHEROSCLEROTIC CARDIOVASCULAR Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Year ned by the atten detached for u Month in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: Atter this certificate has been signe completely filled in by the funeral director, page 2 should be 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No 24a. Was an autopsy performed 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 ☐ Accident 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number nd title of certifier 29b. Signature at D31136

State Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m) 9005 KICBLIDE RD, BALTIMAE UND 21236

Mayre from

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 💚 🗍 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician June Harrison 2007 harles /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner s Hospital Baltimore If Under 1 Year The Johns Hopkins 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1**⋈** M 2□ F Yrs. 212-34-1044 Director Md 70 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 23a or 28a-1 ehow the Medical Examiner total be notified at Y☐Yes 2☐No NA Baltimore Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code death v 1508 Harford Avenue 21202 Funeral 112. Was Decedent Ever in U.S. Armed Forces? USA 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "neturel", or Items Black, White, etc. filed within 72 hours efter 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ 3 ☐ Widowed 4 1 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unemployed Various permit. Pages 1 and 2 should be filed to Department of Heelth and Mantal Hygie Important: If item 27 is marked other 11 any injury or other traumatic event, III once. 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Herbert Harrison Ella Perrin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma McDaniels Sister 1508 Harford Avenue, Apt. 301, Baltimore, Md. 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1.☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Mt. Carmel Cem. 6-18-07 Dundalk, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 Wan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac Dysrhythmia
Due to (or as a consequence of): **Physician** /Medical Examiner Artery Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate 1 Yes 287 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. ours efter death. nerei Director: A filled in by the fu investigation 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature and title of certifier

Marisha 31. Date liled (Month, Pay)

Cook The Johns

9

DHMH 17 Rev 1/2001

ORIGINAL

Tho completed cause of death (Item 23a) (Type, Print)

RES-000

Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland 21287 32 Registrars Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 8:00am M June 17 2007 Weslev Ray Hartwell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5146 Bartholow Road Sykesville Carrol1 If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 M 2 ☐ F 233-36-7454 80 Vrs Director WV April Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 'natural", or items 23a or 28a-f show dical Examiner must be notified at MD Sykesville Carroll 1 ☐ Yes 2 No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21784 USA 5146 Bartholow Road by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or iten Yes 2 No f Yes. Give 1 Never Married 2 Married WWII 1 ☐ Yes 2 ∏ No Specify: white If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) fire equipment salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Myrtle P. Nicholas Robert Lee Hartwell ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5146 Bartholow Rd., Sykesville, MD 21784 Mr. Robert Hartwell (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Memorial 6-21-07 Marriottsville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. OBSTRUCTIVE PULMONARY DISEAGE Immediate Cause (Final disease or condition resulting in death) **Physician** CHRONIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to intrinductions. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed burial-tra Due to (or as a consequence of). Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. **Other significant conditions** con<u>tr</u>ibuting to death but not resulting in the u<u>nd</u>erlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RTERN DIS EASE Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home P 5 Residence 6 □Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 Natural

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: funeral director, After this the filled in by within 24 hours

To the Funeral I
completely filled

Baltimore, Maryland 21215-0036

5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) JUNE 18, 2007

STEID GLENWOON MD 21738

State Registrar

Medical

31. Date filed (Month, Day, Year)

JUN 1 9 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Month Year **Physician** 7 A M Henderson ancy 07 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore 2614 Rader Avenue 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 🗗 F 11-9-1943 Maryland 212-42-9142 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Baltimore Baltimore Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 2614 Rader Avenue 1 and 2 should be filed within 72 hours after death v Health and Mental Hygiene. em 27 Is marked other than "natural", or items 23s ther traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★★No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes XXNo Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) In own home Homemaker injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virginia Bailey George W. Harp 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If Item 27 is any Injury or other trau 2614 Rader Avenue Baltimore, MD 21234 Donald Henderson Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State Moreland Memorial Pk 7/20/07 Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Livery ee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD 21211 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory failhre **Physician** disease or condition resulting in death) /Medical Due to (as a consequence of): Examiner obstructive Chronic nlmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner 20 burial-transit bronchi tis Chronic and resulting in death) Last Due to (or as a consequence of) 45 hr. attending physician for use as the buria Smokini Physician/Medical obacce 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Cardiomyzpath 1, X es 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ➤ No 24a. Was an Malnutrition autopsy perform addiction Nicotine 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

29c. License number

D-14759

29d. Date signed (Month, Day, Year)

6-15-07

certificate be executed Box 68760 P.O. かんかかん ivision or Vital Records, To the Hospital or Attendla within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

少し アシート と Baltimore, Maryland 21215-0036

ferson who completed souse green Thephen R. Jmith, MD who completed suse of death (Item 23a) (Type, Print) \$709 Harford Ray Baltimore, Md. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

MD

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title

6ertif

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Hans Dietrich Heyck June 13 2007 5:11 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Funeral Days Hours Min 1□ M 2□ F June 24 1923 Director 042-30-9368 83 Germany Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. ant: if item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 X No Director MD **Baltimore** Phoenix 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21131 USA Funeral 38 Sunnyview Dr. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: white Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Electrical Engineer Electronic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Swen Hans Heyck Frieda Runge P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11409 Old Hopkins Rd., Clarksville, MD 21029 <u>Johanna H. Martino/daughter</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 6/17/07 M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o important: if any injury or 4 ☐ Donation 5 ☐ Other (Specify) John's Lutheran Ch. Cem. Sweet Air, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Funeral Michael J. Flagie 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MIKS In Wacrania /Medical Due to (or as a consequence of) Examiner weks Securitially list on differs if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner requires that the death certificate be executed use as the burial-tra Due to (or as a consequence of): or Vital Records, P.O. Box 68760, physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 □ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No Q autopsy page perform 1□ Yes or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 No Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 Kother (Specify) \bowtie v S p (φ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at After Division 5 Pending investigation 1 Natural Injury within 24 hours after
To the Funeral Director; Aft MAY 19 2007 UN KNOWN Fell 1 Tes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 38 SUNNYVIEW DRUE, PHOENIX MO Home 💳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Nam, an address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles ST Tonson MD BARON m 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #2, perMD, G869, 7/5/07 TT Continued To Continu 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 Year Month Physician 2:00 AM June 16 2006 Hinsche Daniel J. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester Atlantic General Hospital Berlin
II Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months 1**☑** M 2□ F Hours 55 July 22 1951 Director Maryland 212-50-5957 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r then "natural", or items 23e or 28a-f ehov the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Carroll Westminster Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number HS 21158 705 Norfield Court Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No II Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White ٤ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Para Legal Social Security Admin. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lasko Ann William Hinsche 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) . or other train 705 Norfield Court, Westminster, MD wife Sandy Hinsche Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 Cremation 3 Removal from State Department o important: if any injury or once. June 20, 2007 Westminster, MD Salem UMC Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Burrier-Queen Funeral Home 21. Signature of Funeral Service Licenses 1212 W. Old Liberty Road, Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Score pneumonia
Due to (or as a consequence of): **Physician** /Medical Examiner Sersis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last rena Due to (or as a consequence of): 68760 Physician/Medical IF FEMALE O. Box 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 1 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28b. Time of After t Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. I Director: A 2 Accident 3 🗀 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) e Hospital or At 124 hours after of Funeral Director filled in by 4 ☐ Homicide 1 Certifying Thysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examind: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DS3612 6/16/07 erson who completed cause of death (Item 23a) (Type, Print)

State

-7/22/195,

595

State 31. Date filed (Month, Day, Year)

32. Registra's Signature

3007

Special St. Special St

9733 Healthway Dr. Berlin, MD 21811

Registrar JUN 1 9 2007

			1 - For State Registrar	State of Mar	ylaria		rtificate of			Reg	J. No.2	07	19697
	Physici	an	1. Decedent's Name (First, Middle, La. Alma Decedent's Name (First, Middle, La.	st) olores]	Hood			2. Date Mor Jun	e of Death oth P 1	6 Day	2007	3. Time of Death 3:25P M
	/Medic Examin		4a. Facility Name (If not institution, give	e street and питber)			4b. City, Town, o	r Location of E			4c. County		3.231
	LXdiiii	iei	8009 Escalon Aven				Pasac	dena				Aruno	le1
	Funeral Director		216-22-3208	ex 7. Age (☐ M 2 M F	(In yrs. las	ot birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date (Mo. Nov	of Birth nth, Day, Y	928	9. Birthpl Count	ace (State or Foreign try) MD
	yland now at		Usual Residence of Decedent 10a. State 10b. County	1	Ioc. City,	Town or Lo	cation					10	Od. Inside City Limits
	a-f sh	ctor	MD Anne Ar	unde1	Pasa	adena							1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g	g. Citizen of	What Coun	try?
	ath w		8021 Woodholme C			1	21122				·S.A.		
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medicel Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cub I ☐ Yes 2K No		nz (Specify Ye: Puerto Rican, e	s or No- etc.)	Bla	e - America ck, White, e v: Whi	etc.
ה ה	72 h "natu	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)		(Give	lent's Usual Occup kind of work done	during most of	of working	16	6b. Kind of B	usiness/Ind	ustry
7	within ene. than he Me	duo	Elementary/Secondary (0-12)	College (1-4or 5+)		Hoste	00 NOT use retire SS	a)		l R	Restau	rant	
2	filed Hygi other ent, tl	Be Co	17. Father's Name (First, Middle, Last))				18. Mother's	s Name (First,				
<u> </u>	Aenta Aenta rked tic ev	To B	Morris Gilbert S	tinchcomb				Alma	Naomi	Boyer			
Mary	and N	-	19a. Informant's Name/Relationship (Type. Print)		19b. Mailir	g Address (Street	and Number o	or Rural Route	Number, (City or Town,	State, Zip	Code)
	and 2 ealth m 27		Mr. Terry Gerhard	t /Son			Thomas R						
Daltilliore	Pages 1 tment of H tant: If iter ijury or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y)	l .	n Hav	sition (Name of natory or other place en Mem.Pa	ırk	June 21 2007	' G	len Bu	ırnie,	MD
0	permil Depar Impor any in		21. Signature of Funeral Service Licer	nsee	M014	///	Name and Address Second A		_				
	V 1983		23a. Part1. Inter the diffease, or com shock, or heart failure. List only	plications that caused the	ne death.							1	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	99	nce of):	l Lo	oge	. (e	((Onset and Death
	Examiner	_	Sequentially list conditions,	b	27	· cor	Mom	a				- 1	5 mon Ths
Т	nsit	Examiner	Sequentially list conditions, it is a sequentially list conditions, it is a sequential sequential sequentially sequentiall	The to to date t	er-transform	HUR UNION							
5	execunand and ial-tra	Exa	that initiated events resulting in death) Last	Due to (or as a c	conseque	nce of):							
0/00/	te be ysicia ne bur	edical		_d									
	ertifica ing ph	-	IF FEMALE:			-							
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death. To the Funeral affect death. To the Funeral affector: Affect this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf 1 ☐ Live birth 2 4 ☐ Pregnant at til 9 ☐ Unknown	Fetal d	eath 3	Ectopic pregnanc Other (specify)	у			1	te of delive onth	ry Day Year
ביטם	equires that en signed b ould be deta	by	Part II. Other significant conditions of	ontributing to death but	not resulti	ng in the ur	nderlying cause giv	ren in Part I.	236	e. Did toba 1 ∐ Yes	cco use cont		e cause of death? ably 4 □Unknown
מים וו	: The law r cate has be page 2 sh	Completed								a. Was an autopsy performe Yes	ed2	prior to con death?	osy findings available apletion of cause of
2 2	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:			t 3DDOA Oth	OF	f Death Check				vaugnee 1
5	Physer this eral di	은 -	1 Yes 2 No 27. Manner of eath	28a. Date of Injury	2	NOutpatien 8b. Time of	1 0 DOX	4 Li Nursi			ce 6 XIOth		Restidence
5	th. :: Afte	ition	Natural 5 Pending investigation	(Month, Day)	Year)	Injury	28c. Injur Wor M 1	rk? Yes 2∐No	1		,,		
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury building, etc.	- At home (Specify)	e, farm, str	eet, factory, office		28f. Loc City	ation (Stre	et and Numb State)	er or Rural	Route Number,
	the Hospit in 24 hour the Funera pletely fills	edical	29a. Certifier (Check only one) 1 Sertifying Ph 2 Medical Exam	ysician: To the best of niner: On the basis of e and manner state	xaminatio	edge, death n and/or in	vestigation, in my o	opinion, death	place, and due occurred at th	to the cau e time, dat	se(s) and m e and place,	anner as sta and due to	ated. the cause(s)
	. /	Σ	29b. Signature and title of certifier	lity as	2		29c. Licens	7 93	8	290	I. Date signe	d (Month, L	2007 2007 40 2106/
	15		30. Name and address of person who Moger Garson	completed cause of dea	th (Item 2	3a) (Type, 3 <i>U</i> O	Spital	Dres	1e Gi	lea	Bur	ace a	40 21061
	Sta Registr		31. Date filed (Month, Day, Year)	2007 32. 7 distrar	s Signatur	k A	neuse)						

DHMH 17 Rev 1/2001

			For State Registrar	State of IVI	aryian		iment of i	neaith and Death	Mental H	ygiene Reg. No	00011	1000			
	Physic		1. Decedent's Name (First, Middle, L Howard Eugene He	,					2. Date of D Month 06-14	Death Day	v Year	3. Time of Death 03:20A			
	/Medi- Examir		4a. Facility Name (If not institution, g		·	4	b. City, Town,	or Location of Dea			. County of Dea				
			Genesis Elder Ca	re Hammond	s La	ne	Brook1	vn		A	nne Arı	ınde1			
	Funeral				e (In yrs. i		If Under 1 Year Vonths Days		s. 8. Date of E			rthplace (State or Forei ountry)			
1.	Director		217-18-6166	18 M 2□F 84	+	Yrs.	Northio Buys	Tiodis IVIII	02-03	-1923	3	MD			
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loca	tion					10d. Inside City Limit			
	faryla sho	ō										1 ⊠Yes 2 □ N			
	the N 28a-1	ect	MD Baltim 10e. Street and Number	ore City		Baltimo	re 10f. Zip Code		-	10g Citi	izen of What C				
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notifited at	Funeral Director	3002 Dillon St.				21224			U.S		ouriny.			
	ms 2;	era	11. Marital Status	12. Was Decedent	Ever in U.	S. 13. Wa		Hispanic Origin? (pan, Mexican, Pue	Specify Yes or N		14. Race - Am	erican Indian,			
(0	or iter	교	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give	No				erto Rican, etc.)		Black, Whi				
03	rai", c	b	3 Widowed 4 Divorced	Year or Dates:		11	∐Yes 2⊠ No	Specify:			Specify:	white			
21215-0036	72 hc natu dicai	Completed by	15. Decedent's (Specify only highest g	Education grade completed)		16a. Deceder	nt's Usual Occu	pation during most of w	orkina	16b. Ki	ind of Business	s/Industry			
21	ithin ne. nan "	힡	Elementary/Secondary (0-12)	College (1-4or s	5+)			during most of w							
	filed w Hygiel ther tl	õ	17. Father's Name (First, Middle, La.	a4)		Can Ma	ker	10 14-45-3-14	ame (First, Midd			Can Company			
anc anc	be fi	Be	Henry Heppding,	•					ise All		i Surname)				
ž	should ind Men imarke	٩	19a. Informant's Name/Relationship			10h Mailing	Addron (Ctron	t and Number or I				7:- 0- 1-1			
Maryland	d 2 sho th and t7 is ma trauma		Mr. Howard Eugen	. 50	on /										
	1 an Heal Iem 2		20a. Method of Disposition	e neppuing,		lace of Disposit emetery, crema	IIIIIA AV ion (Name of	e. NE; G	Date Dur		ocation - City or				
ē	Pages nent of h		1 N Burial 2 ☐ Cremation 3					4	20 2007		-	<i>'</i>			
Baltimore,			4□Donation 5□Other (Specify) Glen Haven Mem. Park 06-20-2007 Glen Burnie												
B	permit. Departi importa any inj		1. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, PA 1 Second Ave SW; Glen Burnie, MD 21061												
			23a. Part1. Enter the disease, or co shock, or heart failure. List on									Approximate Interval Between			
	Physician		Immediate Cause (Final	ly one cause on each ii	ne.			aitus.				Onset and Death			
	/Medical		disease or condition resulting in death)	a. Due to (or as	a consequ		CEAN	ENDM							
	Examiner -			b											
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter United Typing Cause (Disease or injury	Due to (or as	a consequ	uence of):									
_	ocute nd transi	Examiner	triat iritiated events	C											
0,	e exe ian a urial-i	Ä	resulting in death) Last	Due to (or as	a consequ	uence of):									
68760,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	edical E		d											
	ertific ding p		IF FEMALE:	20. 16											
Вох	that the death certified by the attending detached for use as	Physician/IV	23b. Was decedent pregnant in the past 12_months?	23c. If yes, outcome	2 Feta	Ideath 3□E	ctopic pregnanc	су			23d. Date of de Month	elivery Day Year			
	the de	ysic	1 ☐ Yes 2 O No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time or a	eatn 5∐€	Other (specify) _	<u>. </u>				,			
P.0	that ted by		Part II. Other significant conditions	contributing to death b	ut not resu	ulting in the und	erlying cause gi	ven in Part I.	23e. Dio	tobacco u	use contribute t	to the cause of death?			
Records,	uires tha signed I Id be det	Completed by	Subdural	Hemato	w.	4			1	Yes 2	□ No 3 □ F	robably 40Unknov			
Ö	S D ×	ete		15-44-12-13		,			24a. Wa		0.45 144				
Re	The law te has b	g							- au	topsy rformed?	prior to death?	utopsy findings availab completion of cause o			
a	n: T fficate or, pa		25. Was case referred to medical	1					1□ Yes			s 2 No			
>	ding Physician: The lav. h. After this certificate has funeral director, page 2	o Be	examiner?	Hospital: 1 [Inpatio	ent 2	ER/Outpatient	3 DOA Ot	h	eath (Check only		6 Doub (0-				
ō	g Phys er this eral dii	<u>ا:</u> ک	27. Manner of Death	28a. Date of Inju	ıry	28b. Time of	28c. Inju		Home 5 Re			ecity)			
Division or Vital	nding ith. r: Afte e fun	tio	1 Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Da	y Year)	Injury		ork?]Yes 2.∏No							
Vis	Atternation description of the by the	ifica	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At ho	me, farm, stree	t, factory, office	!				Rural Route Number,			
Ö	s afte	Certification:	T D T OT I OT O	building, en	c. (Specify	/ /			City of I	own, State	∌/				
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After completely filled in by the funer		29a. Certifier 1 Certifying I	Physician: To the best aminer: On the basis of	of my kno	wledge, death o	occurred at the t	time, date and pla	ce, and due to th	ne cause(s	and manner a	as stated.			
	To the H within 24 To the F complete	Medical	one)	and manner st	ated.				ouned at the tim						
	Viit To	2	29b. Signature and title of certifier				29c. Licen				te signed (Mon				
			1/1	1m	>		D	23465		(115/0	7			

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUN 1 9 2007

DAKWOOD ROAD

Glen Burnie, ma 21061

CIM dress of person who completed cause of death (Item 23a) (Type, Print)

32. Rigistrar's Signature

Records, P.O. Box 68760 Division or Vital JOHN

2007

or Attending Physician: e Funeral I

State

Medical

TARIQ MAHMOOD

29a. Certifier

(Check only one)

29b. Signature and title of certifie

2300 DULANEY VALLEY RD. 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Lattifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760.

3altimore, Maryland 21215-0036

To the Hospital or AttendIng Physiclan; The law requires that the death certificate be executed thin 24 hours af

> State Registrar

29b. Signature and title of certifier

espaid

JUN 1

31. Date filed (Month, Day, Year)

0

29c. License number

20

29d. Date signed (Month, Day, Year)

21229

and manner stated.

N

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Thomas Imhoff 06:23P M JUNE 14, 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Saint Joseph Medical Center Towson Baltimore if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 12 M 2□ F 68 212-36-1956 Nov. 15, 1938 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County York County Pa. York 1 ☐ Yes 2 XNo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 933 Stream View Lane 17403 12. Was Decedent Ever in U.S Armed Forces? 1 Yes, 2 YNo If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No White Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 N/A Analyst AAI Corporation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Lewis Imhoff Marie Cecilia Murphy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 933 Stream View Lane, York, Pennsylvania 17403 Mrs. Mary K. Imhoff (Wife) Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem. June19,2007 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Peaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium, Maryland 21093 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CANCER Due to (or as a consequence of): SEPSIS Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 5 Other (specify) I ☐Yes 2 ☐ No 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28d. Describe how injury occurred

To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Division or Vital Records, P.O. Box 68760, physician s the burial as attending | signed by the a d be detached f certificate has be irector, page 2 s this

Exam Physician/Medical 2 Be Certification:

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

r than "natural", or items 23a or the Medical Examiner must be

Director

Funeral

\$

Completed

Be

ဥ

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

marked

(27)

permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.

Physician

/Medical

Examiner

27 Is marked traumatic e

other t

Baltimore, Maryland 21215-0036

Completed ၉

after death.

I Director: A:
d in by the fu within 24 hours aft

To the Funeral Di

completely filled in

State Registrar

Medical

29a. Certifier (Check only one)

1 Natural

2 Accident

3□ Suicide

4 Homicide

5 Pending investigation 6 ☐ Could not be determined

(Month, Day Year)

28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MARYLAND 21204

29c. License number D46356

29d. Date signed (Month, Day, Year) 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KHOSROW TABASSI 31. Date filed (Month, Day, Year) JUN 1 9 2007

29b. Signature and title of certifier

M. D. 7601 OSLER DRIVE TOWSON, 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Preston PM Ingle 6 14 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8166 North Road Severn Anne Arundel If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days 1**X** M 2□ F Yrs. 11-12-1952 MD 54 Director 220-58-2133 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Director Anne Arundel Severn 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8166 North Road 21144 U.S.A. Funeral 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No white Specify: Specify. ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mass Transit Driver State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Ingle Doris Vaughn ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Barbara Ingle / wife 8166 North Road; Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem. Park 06-18-2007 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, PA 1 Second Ave SW; Glen Burnie, MD 21061 MO1357 Vaneur 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician week Phenomia /Medical Due to (or as a consequence of): Examiner month exoprosea) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural

Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death. Funeral Director: After this certificate has been signed by the attending physician and Division or Vital Records, P.O. Box 68760 funeral director, page 2 should 124 hours at

completely within 2.

5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

D 23809

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Caucer Chr., 22 S. Greene St., Greene baum

June 18, 2007

Caltimore, mo 21201

Doyle 32. Signature 31. Date filed (Month, Day, Year)

2007

and manner stated.

D

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of Marylan	•	rtment of He tificate of D			giene Reg. No.	007	19703
		_	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medio		Margaret	Sones				06	13	07	9:00 au
	Examin		4a. Facility Name (If not institution, give st	reet and number)	CTR	4b. City, Town, or L	ocation of Death	1110	4c. Co	unty of Death	
					tation		Imore If Under 24 Hrs.	8. Date of Birt	N		place (Chata or Foreign
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	Yrs.	Months Days	Hours Min.	(Month, Da	y, Year)	Cou	
	Director	-	246-62-4790 Usual Residence of Decedent	Λ 00				4-9-19	941		N.C.
	/land		10a. State 10b. County	10c. Cit	y, Town or Lo	ation					10d. Inside City Limits
	Man P-f sh	ģ	Md. NA		Balti	.more					1 X Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cou	ntry?
	23a		1828 E. North Ave			21213				SA	
	tems	Funeral	Tr. Marital Clatos	Was Decedent Ever in U. Armed Forces?	.S. 13. V	Vas Decedent of Hisp Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto F	cify Yes or No Rican, etc.)	14.	Race - Ameri Black, White,	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 Æ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates:	1	☐ Yes 2XNo	Specify:		Sp	ecify: B	lack
8	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ant, the Madical Examination to Indiffed at		15. Decedent's Educ	ation	16a. Deced	ent's Usual Occupati	ion		16b. Kind	of Business/In	ndustry
75	hin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	life. C	kind of work done du OO NOT use retired)	ring most or workir	ig .			
7	ad with	6	8th grade			omestic_					le homes
2	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)			1	8. Mother's Name	(First, Middle,	Maiden Su	mame)	
Maryland 21215-0036	Men Men Marke	ဥ	Roosevelt		ston		Moll:		City of To	Epps	
Nar	12 sh h and 7 is m raum	1	19a. Informant's Name/Relationship (Typ	•	25745700	g Address (Street an					o code)
e,	1 and Healtl Bm 2 ther 1		Rico Renteria 20a. Method of Disposition	Friend 20b. F	Place of Dispos	E. North	D	altimor	e, Md 20c. Locat	ion - City or T	own, State
קֿכ	ages nt of I :: # itu	- 1	1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	emetery, cren Crinity	natory`or other place)	·	3-07	Din	ndalk,	ма
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examinational Legical Angology.		*4 Donation 5 ☐ Other (Specify) 21. Signature of Fune I Service License			. Name and Address		arch F.			Ma.
Ba	Dep den de de de de de de de de de de de de de		Brut Miller		1	101 E. No				_	21202
			23a. Part1. Enter the disease, or complic	cations that caused the deat						1101	Approximate Interval Between
	Pnysician		shock, or heart failure. List only on Immediate Cause (Final	(KD)	n Hi	0					Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conseq	uence of):						
	Examiner		Sequentially list conditions, b	ASWD	<u> </u>						
	D #	iner	if any, leading to immediate	Due to (or as a conseq	uence of):						
)	and and	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	. Due to (or as a conseq	uence of):			_		_	
8760,	icate be executed physician and s the burial-transit	ai E			, , .						
687		Physician/Medical	0								
Вох	eath certific attending p	Ž	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna	ancy	Totalia a managara			230	I. Date of deliv	
	death e atte	icia	in the past 12 months? 1 □ Yes 2 ☑ No	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown		Ectopic pregnancy Other (specify)			1	Month	Day Year
P.O.	at the by th tache	hys	9 Unknown					T		4.71	M
	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	by	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cause giver	n in Part I.		obacco use Yes 2□1		the cause of death?
ord	w requir been si should	Completed						-			
Sec	elaw hasb je 2 st	n pie						24a. Was auto	an psy ormed?	prior to co death?	opsy findings available ompletion of cause of
E E	r: The							1 Tes	212 No	1 🗆 Yes	2 No
<u> </u>	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:	EB/Outpation	Other	26. Place of Death	ne 5∐Resi		Other (Spec	ifu)
o	Phys r this sral di	7: To	1 Yes 2 No	28a. Date of Injury	ER/Outpatien 28b. Time of	28c. Injury	at :	28d. Describe			ny)
lon	Attending r death. actor: After by the fune	atio	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work' M 1 □ Y	es 2 No				
Division of Vital Records,	Attencer death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str	eet, factory, office			Street and h wn, State)	lumber or Rui	ral Route Number,
Ö	ital or A										ji ji
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funaral Diractor: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier 1 ☐ Certifying Phys (Check only 2 ☐ Medical Examir one)	sician: To the best of my knooner: On the basis of examination and manner stated.	owledge, deatl ation and/or in	n occurred at the time vestigation, in my opi	e, date and place, inion, death occurr	and due to the ed at the time,	date and pl	d manner as ace, and due	stated. to the cause(s)
	To the within 2. To the I complet	Med	29b. Signature and title of certifier	and mariner distress		29c. License	number		29d. Date	signed (Month	n, Day, Year)
	->-0		DM. MD			D53	7727		6/1	3 07	
	5		30. Name and address of person who co	impleted cause of death (Ite	m 23a) (Type,	Print)	n Blvel	O	11		4400:000
	J		November Bho	may 560		In Kave	n blud	- Bu	MW	Me.	MD21239
	St Regist	ate	31. Date filed (Month, Pal Year) 9 2	32. Registrar's Sign	ature	sale					
	negisi	Tai		434	-						

07-04585	
Richard Jones	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

icitato Jones .		اد For State Registrar	ate of Maryland / De	Certificate of De		ılları iygi	Reg. N	. 200	7 1970
Physicia ledical Exami	an/	Decedent's Name (First, Midd	L. Jones			1 1	Date of Death Month Day Une 15, 2007	/ Year	3. Time of Death 2330 hrs
The second second		4a. Facility Name (if not institution			ty, Town, or Location			4c. County of Death	1
Funeral	H	University Hospital 5. Social Security Number	6. Sex 7. Age (In y		Itimore Jnder 1 Year If Un	der 24Hrs. 8	. Date of Birth(M	M/DD/YYYY) 9. Bir	thplace (State or
Director		056-66-4157 Usual Residence of Decedent	1XM 2F 3	· · · —	onths Days Hou	ırs Min	1 1	Foreig	
id how any	_	10a. State 10b. County	10c. c	Saltimore					10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 864 Bennin	obaus Doa		Zip Code	2.	10g. C	Citizen of What Cou	ntry?
eath with the items 23a	Funeral [11. Marital Status	12. Was Decedent Ever	If Yes, sp	cedent of Hispanic Co pecify Cuban, Mexico			14. Race - Amer White, etc.	ican Indian, Black,
ırs after d tural", or ıminer m	<u>ā</u>		1 Yes 2 X N vorced If Yes, Give Year or Dates: ecify only highest grade completes	1 Yes	2 No speci-		done 16t	Specify: B	ack
nore, MD 21215-0036 sges I and 2 should be filed within 72 hours after death with the Maryland nof Health and Matnel Hygiens. If I fitten 27 is marked other than "natural", or items 23a or 28a-fishe other traumatic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12)		during most of	working life. DO NO	Ŕ	N	Music	Industry
ore, MD 21215-0036 is 1 and 2 should be filed within 7. Health and Mental Hygiers If liem 27 is marked other than er traumatic event, the Medical retraumatic event, the Medical	8	Stanley E.	Jones, Sr.		I	Doris	rst, Middle, Maid	r	
MD 2. Id 2 should alth and M m 27 is man ar aumatic e	٩	Deborah Jon	es (Sister)	360 Lex		Ave. k	Brookly	n, NY	11216
AOFE ages 1 nt of H nt: If i		20a. Method of Disposition 1 Burial 2 Crematio 4 Departion 5 Other S	n 3 Removal from State	20b. Place of Disposition (crematory or other place)		1.1	2 10 7	c. Location - City of	nt NC
Baltin permit. P Departme Importan		21. 6i mature of Funeral Service		22. Na 5151		Breene Sat 1 Pi	Furrer	al Servi	
Physician /Medical		failure. List only one cause	Multiple Cumphet 10/		ode of dying, such a	s cardiac or re	spiratory arrest,	shock, of heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Multiple Gunshot W Due to (or as a consequen			. 6			
	Jer	Sequentially list conditions, if any, leading to immediate	b	nce of):		141			
ted J ansit	Examin	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	nce of):	-				
760, icate be executed sphysician and the burial - transit	Medical	UNPENDED	AMENDED						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		IF FEMALE: 23b. Was decedent pregnant in t past 12 months?	I Live Ditti	2 Fetal de	eath 3 Ecto	opic pregnancy		23d. Date of delive Month	y Day Year
P.O. Box 687 that the death certific ned by the attending p detached for use as th	Physician/		4 Pregnant at time	of death 5 Other (Specify)				
P.O.	ģ	Part II. Other significant condi	tions contributing to death but	not resulting in the under	lying cause given in	Part I.			the cause of death? bably 4 Unknown
ords, P.O. w requires that as been signed be should be detailed	Completed	_					24a. Was an autopsy	prior to	utopsy findings available completion of cause of
tal Recol	Comp						performed 1 Yes 2		es 2 No
Vital hysician: this certif	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatient 3	26.Place of Dea			sidence 6 Other	 er:
ision of Vital Rec Attending Physician: The I r death. ector: After this certificate I by the funeral director, page		27. Manner of Death	28a. Date of Injury (Month, Day Year) Jun 15, 2007	28b. Time of Injury 2223 hrs	28c. Injury at W	- Isi	d. Describe how ubject was sh	, ,	
Division of Vital Records, To the Hospital or Attending Physician: The law requir white 24 hours after death. To the Funcal Director. After this certificate has been st completely filled in by the funeral director, page 2 should b	ertification:	2 Accident Inve	estigation 28e. Place of Injury -	At home, farm, street, fac		, etc. 28	or Town, State)	ural Route Number, City
Divi To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	ပ	29a. Certifier 1 Certifying F	ermined (Specify) Major F Physician: To the best of my kno	wledge, death occurred a	at the time, date and	place, and du	00 Blk. W. Pra	tt St., Baltimore, and manner as sta	ted.
To the within To the complete	Medical	one) 2 Medical Ex	aminer: On the basis of examinat and manner stated.	tion and/or investigation, i	n my opinion, death			place, and due to t	
	2	29b. Signature and title of certif	J. mo		O.C.M.E.			une 16, 2007	o.m., buy, rodr)
57			n who completed cause of death		Inlain con 184D C	1201			
2	tate	31. Date filed (Month, Day, Year) _ 32. Reestrar's Si	111 Penn Street, B	Contract Con	1201			
Regis		11 1 N 1 3	9 2007 Elecen	JE Apar					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Southerine 14 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore

1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) astle 02 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 Months Director 218-96-1713 Usual Residence of Decedent 10a. State 10c, City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 tes 2 No Director 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 21212 Castle Dr 502 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 12 No Specify: Specify: 3 ☐ Widowed 4 Divorced white "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales 50145 Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Elmer Ford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 Is any Injury or other trau once. Balto, MD 21212 20c. Location - City or Town, State 502 APT A CVO 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 1etro Cromotory 6-23-07 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Fin ral Service License II AM 1232 Midvalley Dr. Jessup, PA 18434 23a. Part Finter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Circhosis of the Liver Physician /Medical Due to (or as a consequence of); Chroniz obstructive pulmenay discose Examiner Se juentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examine Cardiamyopathy Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 12 Yes 3 Probably 4 □Unknown 2□ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2. No 2∏ No 1□ Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred Injury 5 Pending within 24 hours after uco....
To the Funeral Director: Aft investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title M, D,of person who completed cause of death (Item 23a) (Type, Pript) 3 7801 York Road Towson, MD 21201 30. Name and addre 1 motor Doyle,

Registrar

31. Date filed (Month, Day, Year)

(Month, Day, Year)
JUN 1 9 2007

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 3:15A M JUNE 2007 /Medical 16 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Hiddle · RehAB KIVER BA HIMORE seriatric if Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Social Security Number **Funeral** 1 M 2 □ F 82 Yrs. 8566 Director 219-12-March 19, 1925 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show unty or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □ Yes 2 No MARY/AND Funeral Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 21220 U.S.A. WINDIASS 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 K Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usuai Occupation 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Eiementary/Secondary (0-12) Addy 8+6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra)AKLEIGH -Nephew Mr. Edward SIOAN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location 1 Burial 2 ☐ Cremation 3 Removal from State 07 Marriettsvice 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility NNINO 05 cpl N. ZAN. Street 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Dale to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ng physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) Yes 2 No detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Aner this certificate has been signed funeral director, page 2 should be de-Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 2 No certificate has 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Mo မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation Injury 1 Matural To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 No 1 ☐ Yes death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

State

31. Date filed (Month, Day, Year)

9

me and address of person who completed cause of death (flora 23a) (Type, Print)

. Registrar's Signature

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUN 1 9 2007

odkina

Baltimore

maryLand

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 6:05 PM Physician 15, Muriel 2007 ramer Tune /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE N/A 7121 PARK HEIGHTS AVENUE #406 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dav. 9. Birthplace (State or Foreign last birthday Social Security Number **Funeral** Days 220-40-9127 1 □ M 2 🗶 F 84 04/06/1923 MD Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10h County 10a State 1 ¥ Yes 2 □ No Director BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21215 7121 PARK HEIGHTS AVENUE #406 Funeral 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give X Year or Dates: WHITE 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 □ Divorced Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) **EDUCATION TEACHER** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARGOLIS WOOLF IDA BARNETT ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9737 SOUTH PARK CIRCLE - FAIRFAX, VA 22039 STUART KRAMER / SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Bunal 2 ☐ Cremation 3 ☐ Removal from State 06/17/2007 WOODLAWN, MD SHAAREI TFILOH CONG. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Matt Les 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) months CanceR **Physician** Kidney /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician The law requires that the death certificate be Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Vear in the past 12 months? ō 4☐Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2 No the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown None Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury Injury at Work? Certification: 27. Manner of Death (Month, Day Year) Injury 5 | Pendina 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D34851 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert T.

State Registrar

31. Date filed (Month, Day, Year)

RMB 500

Blvd R
32. Registrar's Signature

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of M	aryland		artment rtificate					iene	007	1970)
	Physici /Medic		1 1/ 1/2 14 A C L L L L L L L L L L L L L L L L L L								3. Time of Death			
	Examir		4a. Facility Name (If not institution, give	-			4b. City, T			of Death			unty of Death	
			5. Social Security Number 6. Se	Cockwo		t hirthday)	tf Under 1	-Kuil	If Under	24 Hrs o	Data of Diet	80	14-00	
	Funeral Director			М 247 г / Л	85	Yrs.		Days	Hours	Min. Ma	Pate of Birth Month, Pay, Y 21,	1922	West	place (State or Foreign Intry) Virginia
336	Maryland	tor	10a, State 10b, County	imore	10c. City,		cation kvil	le						10d. Inside City Limits
	h with the 23a or 28e st be not	al Director	10e. Street and Number 1801 Wentwort	h Road			10f. Zip (212	234		1	0g. Citizen	of What Cou	-
	should be filed within 72 hours after death with the Maryland nd Menial Hygiene. marked other then "naturel", or Items 23a or 28e-f show imetic event, Ira Madical Exacinatinative multipolati	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 21 If Yes, Give Year or Dates:	Ever in U.S. No		Was Decede f Yes, specif		spanic Ori n, Mexican Specify:	igin? (Specify n, Puerto Rica	Yes or No- n, etc.)		Race - Amer Black, White ec <i>ify:</i>	
Maryland 21215-0036	filed within 72 ho Hygiene. other then "natur ont, tre Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)			(Give life. l	dent's Usual kind of work DO NOT use Cepti	done di retired)	<i>uri</i> ng mosi)	t of working			of Business/I erica	ndustry l Credit
yland	bed day	To Be C	17. Father's Name (First, Middle, Last) John Pinnell							er's Name (Fin innie		Maiden Sur	mame)	
, Mar	1 and 2 sho Health and tem 27 ie ma		19a. Informant's Name/Relationship (T Olive Christian—si	ype, Print) ster		19b. Mailir 7224	ng Address (Street a. Harf	nd Numbe Ford	er or Rural Ro Road–P	ute Number arkvi]	. City or To Lle, Ma	arylan	ip Code) d 21234
altimore,	se to		20a. Method of Disposition 1 ♣ Burial 2 □ Cremation 3 □ I 1 4 □ Donation 5 □ Other (Specify,		Dular	e of Dispo letery cres Ey Vall Garde	sition (Name natory or oth Ley Man 305	e of Per place TOCIA	1 6	Date 6–18–07	T.	imon		aryland
Ball	permit. Page Deportment Important: If any injury o		21. Signature of Funeral Service Licens	ME fac	ble	EX.	Name and NSR	Address EUN EMA	s of Facilit	SERE	ELES	800 I Parl	Harfo kvill	rd Road e,MD 21234
	Physician and bulletinasi sthe pariatransi	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. (Dreade of injury that initiated events resulting in death) Last	a. Due to (or as Due to (or as Due to (or as	a consequer	nce of):	er the mode	of dying	g, such as	cardiac or res	piratory arre	est,		Approximate Interval Batween Onset and Death Clary
P.O. BOX 58/50	The law requires that the death certificate be executed te has been signed by the attending physician and vage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	2 Fetal de	eath 3	Ectopic pred					23d.	Date of delive	very Day Year
	w requires that been signed should be de	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the underlying cause given in Part I. 23e. Did tobacco use contribute to the underlying cause given in Part I.							_				
Vital Records,	(G LT	Completed	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes							prior to co death?	opsy findings available ompletion of cause of			
ō	J Physicien: Th sr this certificate eral director, pag	n; To Be	examiner? 1 Yes 2 NO									(fy)		
	To the Hospital or Attending Is within 24 hours after death. To the Funerel Director: After completely filled in by the funer	ertification;	27. Manner of Death 1							ral Route Number,				
	ne Hospital or At n 24 hours after o ne Funerel Direc bletely filled in by	edical C	29a. Certifier (Check only one) (Check only on								stated. to the cause(s)			
	To the within To the comple	Me	29b. Signature and title of certifier				29c.	License	number		29	9d. Date sig	gned (Month,	, Day, Year)
	1		Wind Kleex	mo				P3	1795			6/1	4107	
V	2		30. Name and address of person who example Market M	mpleted cause of c	leath (Item 23	3a) (Type, 1	Print)	SL	Siz	L 420	2 7	روسان	n n	L 21284
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 9 200	Registr	ar's Signature	Lon	de							,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 17, Day 2007 Year June June **Physician** 11:15am м William Lloyd, Jr. Α. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carrol1 Eldersburg 6504 Ridenour Way E. - Unit 10 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 10, 1928 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 78 ΜĎ Director 219-22-065? Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits a or 28a-f show be notified at 10a State 10b. County 1 ☐ Yes 2√☐ No Director MD Carroll Eldersburg the ! 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21784 6504 Ridenour Way East Unit 1C d other than "natural", or Items 23a event, the Medical Examiner must b by Funeral permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 TYPes 2 □ No If Yes, Give Year or Dates: WWI 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White WWII 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Comptroller Work Accounting 7 is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Altha M. Lee William A. Lloyd, Sr. ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6504 Ridenour Way E., #1C Eldersburg, MD 21784 Health a Mrs. Beverly Lloyd (Spouse) item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any Injury or c once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State All County Cremation 6/25/2007 Sykesville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee AATGHT FUNERAL HOME & Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause and line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Understand Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending plant for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? ąÇ 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 | Yes 2 | 1 | Yes 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation within 24 hours after use....

To the Funeral Director: After a control of the funeral and the 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check on and manner stated

State Registrar 29b. Signatu

and title of certifie

JUN 1 9 2007

30. Name and address of person

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For State of Maryland / Department of State of Registrar Certificate of Certif		ntal Hygien	_001 1211	No. 10-100																
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last) Lanchard 4a. Facility Name (If not institution, give street and number) 4b. City, Town		Date of Death Month Da	Year 3. Time of Death	th M																
	Funeral Director		Genesis Lochraven 5. Social Security Number 214-01-0854 Lock Part of Part o	Baltimore 9. Birthplace (State or For Country) 4 Maryland	eign																		
	Maryland s-f ehow	tor	Usual Residence of Decedent 10a. State			10d. Inside City Lir 1 □ Yes 2X																	
	ath with the 2 23a or 28s	rai Director	10e. Street and Number 1410 Unit D Bonnett Place	21015	t	itizen of What Country? Inited States																	
21215-0036	within 72 hours after death with the Maryland ene. than 'natural', or Items 23a or 28a-f ehow ta Medical Exercites from the notified at	by Fune	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 4 □ Divorced 1 □ Yes, Give Year or Dates: 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. If Yes, specify C	of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ric No <i>Specify:</i>	y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: White																	
	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Heatth and Mental Hygiene. If item 27 Is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, It a Medical Examinating the notified at	Completed by Funeral	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occ (Give kind of work dor iife. DO NOT use ret. Homemake	ine during most of working tired)	16b. F	Kind of Business/Industry Own Home																	
Maryland 2	should be filed nd Mental Hygis marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Reginald Davidson	18. Mother's Name (F Edna Mo	organ	n Sumame)																	
	is 1 and 2 sho of Health and item 27 is ma other trauma		Richard Bussey (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of Disposition		ce, Bel A	or Town, State, Zip Code) Air, Maryland 210' .ocation - City or Town, State	15																
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Add	ory 06/18,	bard Fune	altimore, Marylanderal Home, Inc.																	
L	Pnysician i		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of c shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition			Approximate Interval Between Onset and Death																	
8760,	The law requires that the death certificate be executed to be a second to be a second to be a second by the attending physician and be detached for use as the burial-transit as a second be detached for use as the burial-transit.	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Consequence of):																				
O. Box 6	that the death certifics ed by the attending pl detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of delivery Month Day Year																	
rds, P.	w requires that been signed by should be deta	by	by	þ	by	by	þ	þ	þ	by	by	þ	by	by	by	by	by	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.	23e. Did tobacco	use contribute to the cause of death	
al Records,	iician: The law re certificate has be rector, page 2 sho	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings availa prior to completion of cause death? 1 ☐ Yes 2 2 No	able of																
Division of Vita	Phys this al di	tion: To Be	To B	To B	To B	To B	To B	To B	To B	To B	To B	To B	To B	To B	To B	27. Manner of □ath 28a. Date of Injury 28b. Time of 28c. In 1 2 Matural 5 □ Pending (Month, Day Year) Injury V	-		6 □Other (Specify) ury occurred				
	Hospital or Attending I 24 hours after death. Funeral Director: After tely filled in by the funer	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)																				
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number / / 29d. Date signed (Month, Day, Year)																				
	1.	4	30. Name and address of person who completed cause, of death (Item 23a) (Type, Print)	30661	120	June 16 1 2007) —																
	1		Fingle Rd Balt woll Re 31. Date filed (Month, Minner) 0 2007 32. Registrar's Signature	d - 2/2	-34																		
	Sta Registr		JUNI 9 2007																				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend #21, perDVR, g868, 6/14/0/ TI Certificate of Barri 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician May 20, 2007 11:20 Рм William Penn Lowe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, 5. Social Security Number If Under 24 Hrs. Hours Min. 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Months July 10, Year) **™**M 2□F Days Illinois 329-12-2344 85 Director Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show iral", or items 23a or 28a-f shov Examiner must be notified at 1 X Yes 2 No Directo MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 20851 U.S.A. 13200 Ardennes Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify þ 3 XWidowed 4 ☐ Divorced "naturai" White Completed if Health and Mental Hygiene.
Item 27 is marked other than "natu
other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Person H.J. Heinz 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elva Dunlap ည Sam Norton Lowe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) George D. Lowe 13200 Ardennes Avenue - ROckville, MD 20851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 5/26/2007 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) Baltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility George D. Lowe (per DVR) Chesapeake Crematory 10771 Tucker Street-Beltsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Arteriosclerotic heart disease vears disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ XNo မ 1 Inpatient 2 KER/Outpatient 3 DOA 27. Manner of Death 1 XNatural 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the within 24 hours after deal To the Funeral Orector 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death accurred at the time cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 55410 May 21, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yevgeniy Gincherman, MD 8600 Old Georgetoen Road-Bethesda, MD 20814 31. Date filed (Month, Day, Year)

JUN 1 9 2007

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Mary		artment of F rtificate of			ene2007	97 3										
ı	Physici		1. Decedent's Name (First, Middle, Last	LEVY				2. Date of Death Month June	Day 2007	3. Time of Death										
	/Medic Examin		4a. Facility Name (If not institution, give		TAL	4b. City, Town, o	r Location of Death		4c. County of Death	INNE										
	Funeral Director		LLU 11 / 000	x	yrs. last birthday) 9 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 07/23/19	Year) 9. Birth Cou	place (State or Foreign intry) MD										
	yland how		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits										
	Be-fe	ector	MD BALTIM	ORE	BALTI			1.0	C:::	1 Yes 2 No										
	a or 2	Dir	10e. Street and Number 8911 REISTERSTOWN	ROAD		10f. Zip Code 21208	3	10	g. Citizen of What Cou	intry?										
920	be filed within 72 hours after death with the Maryland stal Hygiene. Id other then "neturel", or Items 23a or 28e-f ehow event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:			dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White											
5-0	72 ho netur	eted	15. Decedent's Edu (Specify only highest grad	ication le completed)	(Give	dent's Usual Occup kind of work done	during most of work	ing 1	6b. Kind of Business/I	ndustry										
Maryland 21215-0036	e filed within Il Hygiene. other then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire KKEEPER	2)		HOME IMPR	OVEMENT										
nd	ild be filed lental Hygid ked other ilc event, II	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, M												
ryla	should be and Mental marked umatic ev	ဥ	MEYER 19a. Informant's Name/Relationship (T)	vpe. Print)	DAVIDSO 19b. Maili		RAE and Number or Run	al Route Number.	ABRA City or Town, State, Zi											
	nd 2 ilth a 27 lc r tre		JUDY ZABA / DAUGH	•					OWN, MD 21											
Baltimore,	Pages 1 and the person of Head of Head of Head ont: If item any or other		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ I	Removal from State		matory or other pla	ce)		0c. Location - City or T											
Itim	그 든 뿐 글		4 □ Donation 5 □ Other (Specify,21. Signature of Funeral Service Licens						NDALLSTOWN N & BROS.,											
Ba	Depa Impo any ir		Matt Lev						KESVILLE,											
	Physician /Medical Examiner	ilner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							Approximate Interval Between Onset and Death										
P.O. Box 68760,	ificate be executed g physician and as the burial-transit	edicai Examiner	that initiated events resulting in death) Last	Due to (or as a co	Due to (or as a consequence of):															
	that the death certific ed by the attending p detached for use as	by	by		hysician/N	hysician/N	hysician/A	hysician/N	hysician/N	hysician/A	hysician/N	hysician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							Date of delivery Month Day Year
	se us				Part II. Other significant conditions co	acco use contribule to s 2 □ No 3 □ Pro	the cause of death?													
al Records,	The ate h page	Completed							ed? prior to condeath?	opsy findings available ompletion of cause of										
Vital	Physicien: Th r this certificate ral director, paç	To Be	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \subseteq \text{Vio} \)	Hospital: hpatient	2 ER/Outpatie	nt 3□ DOA Oth	and a	h <i>(Check only one</i> ome 5 ☐ Resider	nce 6 ☐ Other (Spec	ify)										
Division of	ding h. Afte fune																			
Divis	tel or Atten rs after deat el Director: ed in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	eet and Number or Rui State)	al Route Number,															
	To the Hospitel or At within 24 hours after o To the Funerel Directompletely filled in by	edical	(Check only of Medical Every	vsician: To the best of my iner: On the basis of exa and manner stated.	mination and/or in	vection in my	pointing death accur	red at the time dat	auth has each has et	to the cause/el										
)	To the within To the comple	×	29b. Signature and title of certifier 30. Name and address of person who ce and address of person who ce are also address of person who ce ar	iles		290 0000	731	3 7	a. Date signed (Month	Lod 7										
l	0		30. Name and address of person who c	ompleted cause of death	(Item 23a) (Type	Print ALTO.	Mp2	1133												
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	07 32 Registrar's	Signature	ale														

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** montague 12:08 OLan 200 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** BAYV Jew Center etmore medical If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 1 1 M 2 □ F Days 283 7-32-Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside Ofty Limits oriant: If item 27 is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the M-dical Examiner must be notified at 1 Ves 2 No Director ma. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status and 2 should be filed within 72 hours after ealth and Mental Hygiene. m 27 is marked other than "natural"; or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Blac 1 ☐ Yes 2 ☑ No Completed by Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Jothe Elementary/Secondary (0-12) mainknance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be na 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bacto. Department of Health Important: If item 27 Perdue Baltimore, Pages 1 Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 Removal from State 19 -0 75 ☐ Other (Specify) materi 4 Donation 22. Name and Address of Facility 21. Signature of Juneral Service Licen Fold HILTON march reneral ma Approximate Interval Between Onset and Death Enter the liseas or leaf failure. , or complications that caused the death. Do not enter the mone of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Lause (Final **Physician** EJGP PAGEA work disease condition resulting in death) CARVETA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760, 🎺 Due to (or as a consequence of): Physician/Medical IF FFMALE 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: ٥ 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA 4 ■ Nursing Home 5 □ Residence 6 □ Other (Specify) After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 4 Natural 5 Pending М 1 □ Yes 2 □ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗲 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 47945 JUNE 19 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

ひろして

2007

31. Date filed (Month, Day, Year)

ZUT

VIDZUNUT

WI

21264

1115

07-04632

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ernesto Molfino State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day June 17, 2007 1323 hrs **Medical Examiner** Ernesto Molfino 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Howard General Hospital Columbia Howard If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreian Months Days Hours Director 1942 1 X M 2 July 31. Country) Peru 375-60-2531 64 Usual Residence of Decedent 10d. Inside City Limits Ä 10a, State 10b. County 10c. City, Town or Location 1 Yes 2 X No 28a-f shov Ellicott City Maryland Howard permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: Hit lim 27 is marked other than "natural", or items 23a or 28a-f sho hijury or other traumatic verus, the Medical Examiner must be notified at once. rector 10e. Street and Number 10g. Citizen of What Country? ö 2918 Montclair Drive 21043 **USA** 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married Yes 2 X No If Yes, Give Yeer 3 Widowed Divorced 1 X Yes 2 No specify: Peruvian Specify: Caucasian à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Self Employed 5+ General Surgeon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jose V. Molfino Maria Cordero 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Susan M. Molfino, Wife 2918 Montclair Drive Ellicott City, Maryland 21043 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 06/19/07 Baltimore, Maryland Metro Crematory Inc. Donation 5 Other Specify ²² Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryl 21. Signature of Funeral Service Licensee Thomas Gregor 🦪 Maryland 21228 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical attending physician for use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death Month 2 past 12 months? Pregnant at time of 5 Other (Specify) 1 Yes 2 No 9 Unknown death Unknown this certificate has been signed by the att director, page 2 should be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2 V No Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: Other, Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other this 1 V Yes After the 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 V Natural Yes 2 No within 24 hours after death

To the Funeral Director;
completely filled in by the f Director; d in by the f 5 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) determined Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 29b O.C.M.E. June 18, 2007 ame and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Laron Locke MD 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 3. Registrar's Signer State

DHMH 17 Rev 1/2001 **OCME 2006**

Registra

Q

7-04550		Ple		e or Print in							jible.		
oseph C. Muelle		4 5 - 04-4	St	ate of Maryla	•			nd Men	tal Hygie	ene	,	$^{2}00$	7 1971
		1- For State Registrar			Ce	rtificate	of Death				g. No.		
Physicia	_	Decedent's Name								ate of Death Ionth		Year	3. Time of Death
ledical Exami	ner	-	n C. Mu							ine 14, 20	007		1014 hrs
				n, give street and nui	mber)		4b. City, Town, o	or Location of	of Death		4c. Coun	ty of Death	1
		4508 Valley					Baltimore	Line					
Funeral Director		Social Security N	lumber		7. Age (In yrs.	last birthda	/) If Under 1 Ye Months Da			Date of Birth	n(MM/DD/YY	Foreig	thplace (State or
Director		212-26-86	548	1 M 2 F		77	Yrs.			b. 21	, 1930) Co	ountry) MD
		Usual Residence of 10a, State	f Decedent 10b. County		100 City	. Town or L	ocation						10d. Inside City Limits
w any		MD N/A Baltim			•							1 X Yes 2 No	
Aaryland 28a-f show 1 at once.	ţ			_	ъ,	11011110							
Mary r 28a	Director	10e. Street and Nu					10f. Zip Code			10	g. Citizen of		ntry?
n with the Maryland ms 23a or 28a-f sho be notified at once			alley V	Jiew Ave.			2120				US		
th wi	uneral	11. Marital Status 1 X Never Marrie	ed 2 M	12. Was Dec	edent Ever in t prces?	J.S. 13	 Was Decedent of H If Yes, specify Cubic 					ace - Amer 'hite, etc.	ican Indian, Black,
or dea	Ē	1 Yes 2 No									Specify: White		
s afte	ò	3 Widowed		orced If Yes, Give Year or Dates: cify only highest grad			Yes 2 X N			dono	Specif 16b. Kind of	7.	
hour "nate	ted	Elementary/Seco		College (1			ng most of working li			Jone	. Killa oi	business/	industry .
36 hin 72 than dical	륍	7	madiy (0.12)	Conege (1	-, 0, 0, ,	Heat	ter				St	eel	Company
d with	Completed	17. Father's Name	(First, Middle	Last)		1		18.Mother	r's Name (Firs	st, Middle, M			
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be	Clemens	s W. M	ueller, Sr				Ros	se E. I	onte		,	
212 Suld bould b	T0	19a. Informant's Na				19b. M	ailing Address (Str	eet and Nun	nber or Rural	Route Num	ber, City or T	own, State	e, Zip Code)
MD d 2 sho lith and n 27 is aumati		Charles V	J. Mue	ller, Sr./	Bro.	[29 I	David Lee	Dr.,	Hanove	er, Pa	. 173	331	
e, lead I and Healt Healt I tram		20a. Method of Dis					sposition (Name of cor other place)	cemetery,	Da	te	20c. Location	on - City or	Town, State
nor ages ant of att. If	ı	1 X Burial 2		Removal fro	om State Sa		Heart of	Jesus	6/18/2	2007	Baltin	nore,	Md.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	-	4 Donation 5 21. Signature of Fu			1		22. Name and Addre						
Inj. III. De per		State	weo	Rine	ken		9705 Bela	air Ro	oad, No	tting	ham, N	1d.	21236
Physician				complications that ca	used the deat	n. Do not er	ter the mode of dyin	g, such as c	cardiac or res	piratory arre	est, shock, or	heart	Approximate Interval Between Onset and
/Medical		failure. List on Immediate Cause (A 41 1	otic Cardio	vascular	Disease						Death
Examiner		or condition resulting		Due to (or as a	consequence	of):							
		Sequentially list conditions, b											
	Examiner	if any, leading to in cause. Enter Unde	erlying Cause		consequence	Of):							3
=	xal	(Disease or injury t events resulting in		Due to (or as a	consequence	of):							
executed an and al - transi				d									
) be exe ician :	dical	UNPENDED		AMENDED									
30x 68760, death certificate be e e attending physicia I for use as the buria	sician/Med	IF FEMALE: 23b. Was decedent	nreonant in t		outcome of pre	gnancy						e of deliver	
certif	lä.	past 12 months		I L Live D	irth ant at time of d	eath 5	. otal coatil	3 Ectopi	c pregnancy		Month	1	Day Year
Box e death the atte	ysic	1 Yes 2	No 9 Un	known 9 Unkno		5	Other (Specify)						
that the d	Phy	Part II. Other signi	ificant condi	ions contributing to	death but not	resulting in	the underlying cause	e given in Pa	art I.	23e. Did to	bacco use co	ontribute to	the cause of death?
ords, P.C w requires that is been signed b	b	Prostate C	ancer							1 Yes	2 🗸 No	3 Pro	bably 4 Unknown
ds,	Completed									24a. Was a			utopsy findings available
COr law I has t	du									autops		prior to death?	completion of cause of
Re The ficate	S										2 V No	1 \ Y	es 2 No
Vital Rechysician: The this certificate director, page	Be	25. Was case refer examiner?	red to medica	Il Inquitale		7		Other	(Check only				
F Vi	P	1 ✓ Yes 27. Manner of Deat	2 No	28a. Date	npatient 2	ER/Outpa		ijury at Work	Nursing Ho		Residence now injury occ		er: Scene
ision of Vital Rec Attending Physician: The I ar death. ector: After this certificate by the funeral director, page	Ë	1 V Natural	5 Pen	(Month	, Day,Year)	200. 1111		Yes 2	_	. Describe ii	iow injury occ	Jurreu	
IVISION or Attendather death Director:	cati	2 Accident		stigation							Vicinity of the		LD (All of a Cit
Divi	Certification:	3 Suicide		d not be	e of Injury - At I	nome, rarm,	street, factory, office	e bullaing, e	etc. 281.	or Town, St		mper or K	ural Route Number, City
ospitz hours inera		4 Homicide 29a. Certifier		(Opcony)	4 -5 1	d		data to the	1	4 - 4b - :	*/*) c = d		4- d
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	Medical	(Check only		hysician: To the bes miner; On the basis o	of examination								
To I To I	Med	29b. Signature and		/ and manner s	tated.	-		nse number					onth, Day, Year)
	-	0/1	111	LIVX	1/11			C.M.E.			June 16		, ,
	4		16	N / /	101						53116 10.	, _50,	
10		30. Name and addit Susan Hoga		who completed caus Assistant Medic		,	Penn Street, Ba	altimore.	MD 21201				
,							,						

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2007 **Physician** 8:48pm M Marion L. Mullaney June 16, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 07-13-1941 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1 □ M 2 😾 F 65 Maryland Director 214-40-1506 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2X No Harford Joppatowne Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 403 Avery Ct 21085 Funeral 14. Race - American Indian, . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) filed within Hygiene. Housewife Own Home th and Mental Hygiei 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Nicklow Wilbur J. Mitchell ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Department of Health a Important: If Item 27 is any injury or other tra 403 Avery Ct Joppatowne, MD 21085 John Mullaney (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 06-19-2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air ele meker Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SCPSIS **Physician** /Medical Due to (or as a consequence of): Examiner tra-abdomin Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit Exami attending physician pe Physician/Medical for use as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an perform certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Many fer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Box 68760. P.0. Division or Vital Records,

|V/ いしのかもの |V/にいらい Baltimore, Maryland 21215-0036

Medical

State Registrar

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

6 Could not be determined

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

6701 N. Charles St. Baltimure MD 21204

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

MATELIS, CLARA

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAMDALLAH 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Hamdallah

900 Caton tue, Baltimore 32. Pagistrar's Signature

29c. License number

P19383

21229

29d. Date signed (Month, Day, Year)

June, 8, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Marsialia 4:10 P M June 17 FOOS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorztenwest Rundullstown Bultimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Months Hours Year) **X**□M 2□F 87 Director 160-18-1787 11,1919 Nov. Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 1 XIYes 2 □ No 7 is marked other than "natural", or items 23a or 28a-f si traumatic event, th∗ M∗di-al Examiner must be notified Director Maryland Carroll Manchester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3311 Kensington Square 21102 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examinar 1 ∑ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Produce Manager Grocery Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Salvatore Marsiglia Mary Zanti 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Marsiglia - wife 3311 Kensington Square, Manchester, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) June 20a. Method of Disposition 22,2007 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation Stother (SpecEntombment Dulaney Valley Mem. Gardens Timonium, Md. 22. Name and Address of Facility Eckhardt Funeral Chapel P.A 21, Signature of Funeral Service Licensee Her BY 3296 Charmil Dr. Manchester, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (orbs a consequence of): Hourt /Medical **Examiner** treemaya Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Atheroscherotic Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

To the Hospital or Attending Physician: within 24 hours a To the Funeral

12

State Registrar

Medical

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Levin Leve Yorke DO Northwest the pitch

29c. License number

40055644

Northwest Hospital 5101 Old Court Rd Randallstown MI

29d. Date signed (Month, Day, Year)

17, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lease	Type of Fillit in Die	ick indelible lik.	Liisure Ali Co	phies Wie rec
	State of Maryland /	Department of He	ealth and Menta	al Hygiene

officially Maidonas		1- For State Registrar State of Maryland / Department of Health and Mental F		eg. No. 201	17 1372
Physicia Medical Examir	ın/	1. Decedent's Name (First, Middle,Last)	2. Date of Deat	h	3. Time of Death
neoicai Examir	ier	Johnny Maldonado 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea	June 16, 2	4c. County of Deat	1813 hrs
		St. Mary's Hospital Leonardtown		St. Mary's	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 F 53 52 Yrs. If Under 1 Year If Under 24H Months Days Hours M Usual Residence of Decedent	in	th(MM/DD/YYYY) 9. Bi Forei 1954 1953	
any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
laryland Sa-f show at once.	5	PR Mayaguez Mayaguez			1 Yes 2 X No
ith the Maryland 23a or 28a-f show notified at once.	Il Director	10e. Street and Number Villa De Algarrobo #204 Villa Te Algarrobo 103 10f. Zip Code 00680		og. Citizen of What Cou	
fter death wi I", or items	by Funeral	11. Marital Status 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Yes 2 X No 1 Yes 2 No specify: Pue	to Rican, etc.)	. White, etc.	rican Indian, Black,
11215-0036 Id be filed within 72 hours a dental Hygiene. narked other than "natural event, the Medical Examin	ompleted t			16b. Kind of Business	Industry
5-003 led withii Hygiene. other th	m o	12 4 Engineer 17. Father's Name (First, Middle, Last) 18.Mother's Nam	ne (First, Middle, N	Mechanical	
21215-0036 All be filed within 7 Mental Hygiene. marked other than	Be C			lga Acevedo	
O 21 should I nd Mer is man	၉	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of	Rural Route Num		e, Zip Code)
nore, MD 2 ages I and 2 shou nt of Health and N tt: If item 27 is n other traumatic		Marlen Palmero/ Employer 7665 Corporate Center 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	er Drive Date	Miami, FL 20c. Location - City or	33126 Town, State
# # # # # # # # # # # # # # # # # # #		1 Burial 2 X Cremation 3 Removal from State crematory or other place)			
Baltimore, permit. Pages I ar Department of Her Important: If ite Imjury or other tr	-	21. Signatur Fun-ral Service Licensee Fuller and Ld P1edad 0/2		Mayaguez, BO5 Harford	Puerto Rico
	- 4	Multi Class Leonard J. Ruck,	Inc. Ba	iltimore, M	D 21214
Physician /Medical xaminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
/		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.			
	iner	if any, leading to immediate Due to (or as a consequence of):			
d Sit	Exam	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
760, icate be executed by physician and the burial - transit		d. V AMENDED #7. DerFH. (869, 7/16/07.TT// 23a,2/,P	erMFg869.	7/20/07 TT	_
60, ate be e hysicia e buria	Medical	UNPENDED X AMENDED #7 per FH . 0869, 7/16/07 TT // 23a, 2/, p #10e, 10b, 17, 18, per ME, 2808, 6/28/07 TT // # IF FEMALE: 23c. If yes, outcome of pregnancy	8 perFH. G	869. 7/10/07 '	<u> </u>
P.O. Box 687 that the death certification by the attending p	sician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown	nancy		Day Year
O. E at the d by the d stached	/ Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
S, P. Lires th	ed by		1 Yes	2 No 3 Pro	babły 4 🗸 Unknown
Records, F The law requires cate has been sign	Completed		24a. Was a autop perfor	sy prior to med? death?	utopsy findings available completion of cause of es 2 No
ician: s certifi	Be	25. Was case referred to medical examiner? Hospital: Use of Death (Chec			
	tion: To	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No		Residence 6 Other	er:
Divisi Divisi pital or Att burs after de eral Directo	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S or Town, S		ural Route Number, City
DIVI	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.		and place, and due to th	ne cause(s)
ا کر پای	Σ	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed <i>(Mo</i>	onth, Day, Year)
18		30. Nam. and a fress of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	1201		
Sta Registr	7.2				
DHMH 17 Rev 1/20	01	ORIGINAL			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 15 Loretta Moxley June 2007 10:33 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunset Ridge Assisted Living Frederick Frederick 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X** F Months Days Hours Min Director 82 4 215-20-9290 Jan 1925 Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No MD Frederick New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15603 Wild Rose Court 21776 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc Yes 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify à If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Md. School for Deaf Secretary 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Felix Shorb Edith Muskull 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau Katie Keilholtz 249 Consiler Lane, Hedgesville, WV (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Locust Grove Cemetery June 19, 2007 Mt. Airy, MD 22. Name and Address of Facility Burrier-Queen Funeral Home 21. Signature of Funeral Service Lice 1212 W. Old Liberty Road, Winfield, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Phim disease or condition resulting in death) 2 years /Medical to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Sunset Assided 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 4 in 4 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred

requires that the death certificate be executed and burial-tra physician a Box 68760 as attending p for use as signed by the a d be detached f P.O. Division or Vital Records, aw has e 2 page certificate Physician: director this funeral After or Attending

28a-f show

ò

or items

'natural"

marked other than

h and Mental F

72 hours after

filed withi Hygiene.

Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

Certification: within 24 hours after com.

To the Funeral Director: Aft

1 Natural 5 ☐ Pending investigation

2 Accident 3 ☐ Suicide 4 Homicide

29a. Certifier (Check only one) 6 ☐ Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatule and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

sh 9 2007 31. Date filed (Month)

65 22. Registrar's Signature 70

State Registrar

To the Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2007 JUNE MARIANNA MARKEN 16 10:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🔀 F 67 Director Dec 23 1939 193-34-8454 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anne. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No **Funeral Director** MD Mt. Airy Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1096 Long Corner Rd. 21771 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 [★No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) St. Joseph Hospital 12 Registered Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Richard Garrity Marion Wolfe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack Marken (husband) 1096 Long Corner Rd., Mt. Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) June 20 2007 1 Surial 2 □ Cremation 3 □ Removal from State St. Peter the Apostle 4 ☐ Donation 5 ☐ Other (Specify) Mt. Airy, MD 22. Name and Address of Facility signative of Funeral Service Licensee Burrier-Queen Funeral Home 1212 W. Old Liberty Rd., Winfield, MD art1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immedia e Cause (Final disea or condition ulting in death) **Physician** ocadia 0-1 hr /Medical Due to (or s a consequence of): **Examiner** 20 ter Sequentially list conditions, if any, leading to immediate cause. Error briderlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed bunial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Snuadt 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 10 Natural 5 Pending investigation 1 ∏Yes 2 ∏No 2 Accident 3☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and little of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0055104 30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

202, Mt. Airy, MD

Suite

1502 S. Main St,

DHMH 17 Rev 1/2001

State

Registrar

Gail T. Griffin

JUN 1 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** JUNE 2007 Α **ESTHER** MILLER 15 2:15 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PIKESVILLE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | 10/21/1909 BALTIMORE NORTH OAKS HEALTH CENTER Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 97 217-32-9277 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☐ No Director BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 725 MT. WILSON LANE #3 21208 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Saltimore, Maryland 21215-0036 WHITE Specify: Specify: Completed by 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) SECRETARY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ABRAHAM COHEN KATE ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 30 STAGS LEAP COURT - BALTIMORE, MD 21208 MARILYN SCHLOSS / DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery crematory or other p Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State BNAI ISRAEL CONG. 06/17/2007 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Myhermers /Medical Due to (or as a consulence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) intervalunt Hospital: 1 ☐ Yes 2 ☐ Xo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hor To the Fune completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D47683 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21136 MD Raymond Miller Man Street Renks town 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of H rtificate of I			ene g. No. 2 () () T	1 1972 :
	Physici /Medic		1. Decedent's Name (First, Middle, Las	,	ard Manc	uso		2. Date of Death Month	Day Year	3. Time of Death 21: 49 M
)	Examir	_	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of Dea	none
	Funeral Director		114.54.2144	7. Age	(In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Septemb	^{9. Bi} er 22, 1943	rthplace (State or Foreign Country) New York
	show dat	_	Usual Residence of Decedent 10a. State 10b. County	Dolling and	10c. City, Town or Lo	ocation	0-4			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the Ma a or 28a-f a	Director	Maryland 10e. Street and Number 1919 Tadcaster Ro	Baltimore		10f. Zip Code	Catosnville 21228		g. Citizen of What C	^
9	be filed within 72 hours after death with the Maryland ntal Hyglene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	/ Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give	0	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 □ No	ispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	ite, etc.
21215-0036	72 hours natural"; lical Exa	eted by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed (Specify only highest gra	Year or Dates: ucation	16a. Dece	dent's Usual Occup	ation	kina 1	6b. Kind of Busines	White s/Industry
1212		Completed	Elementary/Secondary (0-12)	College (1-4or 5- 5+	- life	DO NOT use retired	anical Engine		Industrial	couplings & joints
	should be filed of Mental Hygis marked other matic event, the	Be	17. Father's Name (First, Middle, Last) Samu	el Mancuso			18. Mother's Nam	ne (First, Middle, M	laiden Surname) ephine Qualia	na
2	nd 2 saith ar 27 is r trau	욘	19a. Informant's Name/Relationship (7		19b. Maili				City or Town, State, aryland 21228	Zip Code)
Baltimore,	Page nent o int: If iry or		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Opnation 5 □ Other (Specify			osition (Name of ematory or other place St. John's Cer	1	Date 2 06/18/07	20c. Location - City o	or Town, State
Balt	permit. Departn Importa any inju		21 Ign Just of Figneral Service Lice	el mo	05.32	3871	K Funeral Ho Old Columb	ia Pike Ellico	tt City, MD 21	
1	Physician /Medical		23a. Fart1. Enter the disease, or completock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. SEP	Z Z			or respiratory arre	sst,	Approximate Interval Between Onset and Death
le le	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	INATORY	FAILU	ll C			6 days
8760,	icate be executed physician and s the burial-transit	dical Examiner	that initiated events resulting in death) Last	C. Due to (or as a	a consequence of):			***		/
. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3	□Ectopic pregnanc	у		23d. Date of o	lelivery Day Year
rds, P.O	quires that n signed by uld be deta	by	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in the	underlying cause giv	ven in Part I.			to the cause of death? Probably 4 □Unknown
I Records,		Completed						24a. Was ar autops perform 1∐ Yes 2	y prior t	autopsy findings available o completion of cause of ? es 2 🛣 No
Vita	yslclan: is certific director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2☑ No	Hospital: 1 X Inpatie	nt 2 ☐ ER/Outpatie	ent 3 DOA Oth	OF:	ath (Check only on	e) ence 6 □Other (Si	naciful
ion or	Ing Ph	ation: To	27. Manner of Death 1 ANatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da)	ry 28b. Time	of 28c. Inju Wo		1	w injury occurred	эесну)
Division	ial or Atte s after des al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injubuilding, etc	ury - At home, farm, s c. (Specify)	treet, factory, office	J. J	28f. Location (St. City or Town		Rural Route Number,
	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical (nysician: To the best on the basis of and manner sta	aummination and/or	incontinuation in more	aninian dandle ann	compared and the address of		
			29b. Signature and title of certifier	Bailon	eath (Item 23a) (Type	29c. Licens	5 - 000	2	9d. Date signed (Mo	
	13	+	30. Name and address of person who	completed cause of d	eath (Item 23a) (Type	SPITAL O	+ BALTIO	NORE		
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	d'i				
DH	MH 17 Bev 1/2	2001	JUNT 3 COUL	THE STREET	The Jages					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

07-04561 David Merlin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

to a contract of the contract	20	107	ì	9	-	2
---	----	-----	---	---	---	---

		I- For State		Certif	icate of	Death		Reg. No. 1	No.	3. Time of Death
Physicia al Examir	ın/ ner	Decedent's Name (First, DAVID				MERLIN		Month Da June 14, 200	Year 4c. County of De	1558 hrs
		4a. Facility Name (if not in	stitution, give street an	d number)	4	b. City, Town, or L Grantsville	ocation of Death		Garrett	atri
		I-68 Eastbound	6. Sex	7. Age (in yrs. last	birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birth(MM/DD/YYYY) 9.	Birthplace (State or
Funeral Director		5. Social Security Number			Yrs	Months Days	Hours Min.	08/09/1		reign Country) NY
Zili dotto:		092-16-62 Usual Residence of Dece		F 83				00/03/1	<i>y</i>	10d. Inside City Limits
any		10a. State 10b. C		10c. City, To	own or Locati	on				1 Yes 2 No
Aaryland 28a-f show 1 at once.	ō		AYETTE		UNI	ONTOWN 10f. Zip Code		10a.	. Citizen of What C	Country?
Maryl.	Director	10e. Street and Number						1.23	II.S.A	i
th the 23a or notifie		452 UNION	STREET	Decedent Ever in U.S.	13. Wa	15401 as Decedent of His	panic Origin? (Spe	ecify Yes or No-	14. Race - Ai	merican Indian, Black,
ath wi	neral	1 Never Married 2	X Married Arm	ed Forces?	If Y	es, specify Cuban	, Mexican, Puerto I	Rican, etc.)	White, et	c.
fter de	y Fun		Divorced If Yes, Giv	re Year		Yes 2 X No			Specify: 6b. Kind of Busine	WHITE
ours a atura xamin	d by	15. Decedent's Education	on (Specify only highes	- J	i6a. Deceder during m	nt's Usual Occupat nost of working life	tion (Give kind of w DO NOT use retir		ob. Kind of Busine	sss/iiiddati y
n 72 h	plete	Elementary/Secondary	(0-12) Colle	ege (1-4 or 5+)	OWNER		٠.		HOME FUR	NISHINGS
5-0036 led within 7 Hygiene. other than	Completed	17. Father's Name (First,	Middle, Last)		OMINER		18.Mother's Name	(First, Middle, Ma	iden Surname)	
21215-0036 Und be filed within 72 hours after death with the Maryland houtal Hygiene marked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once	Bec	UNOBTAIN	ABLE		AINABL	_E	SARA	Davida Niversia	or City or Town	LEBIN State Zip Code)
	ို	19a. Informant's Name/R			19b. Mailir	BROWNS M	et and Number or F	T - HERD	ON VA 2	0170
e, MD 21 I and 2 should Health and Me Item 27 is ma		JUDY BERGM		20b. Pl	ace of Dispo	sition (Name of ce		Date	20c. Location - Ci	
Baltimore, permit. Pages I ar Department of Her Important: If ite		1 X Burial 2 C	remation 3 X Remo	oval from State	ematory or o		06/1	9/2007	HOPWOOD.	РΔ
Baltimore permit. Pages 1 s Department of Ht Important: If it		4 Donation 5 0	Other Specify: Service Licensee	HUL	Y SOC	Name and Addres	s of Facility	SOL LEVI	NSON & E	BROS., INC.
Balt permit. Depart Impor	l	Do to	1			8900 RE1	ISTERSTOW	N ROAD -	- PIKESVI	LLE, MD 21208
ำhysician		23a. Part I. Enter the dis	ease, or complications le cause on each line.	that caused the death.	Do not enter	the mode of dying	, such as cardiac c	r respiratory arres	st, snock, or near	Between Onset and Death
/Medical Examine		Immediate Cause (Final	disease a. Multipl	e Injuries	١.					
		or condition resulting in	b	or as a consequence of). 					
	į	Sequentially list condition if any, leading to immediate cause. Enter Underlyin	iate Due to (or as a consequence of):					
	Evamino	(Disease or injury that in events resulting in deat	nitiated	or as a consequence of	·):					
cuted ind transit	ů		d							
760, icate be executed g physician and the burial - transit	Modical	UNPENDED		perFH, G868		<u>/07 TT</u>			23d. Date of d	elivery
3760, ficate be g physical street the burner of the burner			nant in the 23c.	If yes, outcome of pregr Live birth	2	Fetal death 3	Ectopic pregr	ancy	Month	Day Year
Box 687 le death certific the attending pad for use as t		past 12 months?	4 4	Pregnant at time of de	- 4 -	Other (Specify)			1	
Box he death of the atter	and the man	Part II. Other significa		Unknown	esulting in th	e underlying cause	e given in Part I.			oute to the cause of death?
ires that the signed by	in i	<u>त</u> े						1 Yes		Probably 4 Unknown
ds, equire	ning							24a. Was autop	sy pr	ere autopsy findings available for to completion of cause of
COF e law r e has b	115 7 a	<u> </u>						perfo 1 ✓ Yes		eath? ✓ Yes 2 No
of Vital Records, ng Physician: The law require ther this certificate has been a			to medical			26.Pla	ace of Death (Chec			
Vita ysicia his cer	direct	examiner? 1 Ves 2	No	1 Inpatient 2	ER/Outpati			sing Home 5	Residence 6 w	
of ing Ph		27. Manner of Death		a. Date of Injury (Month, Day Year) un 14, 2007	28b. Time 1545 hrs		njury at Work? Yes 2 ✔ No	Driver auto	fixed object o	ollision
sion ttendi death.	y the i	2 Accident	Periolity	8e. Place of Injury - At h	nome farm, s					er or Rural Route Number, City
Division tal or Attendings after death.	filled in by the	1 Natural 5 2 Accident 3 Suicide 6 4 Homicide	Could not be	Specify) Interstate/				or Town, S I-68 Eastbou	State) nd, Grantsville,	Md.
ie g pi						ccurred at the time	e, date and place, a	nd due to the cau	se(s) and manner	as stated.
thin 24	completely	(Check only one) 2 Me	edical Examiner: On th	the best of my knowled e basis of examination nanner stated.	and/or invest	tigation, in my opin	nion, death occurre	d at the time, date	and place, and	ed (Month, Day, Year)
F. W. T.	00	29b. Signature and titl	e of certifier				ense number C.M.E.		June 15, 2	
107		high	, ,	100					13,13	
30			Assistant Medic	eted cause of death (Itel	_{m 23a)} 1 Penn S	treet, Baltimor	re, MD 21201			
	Sta	Ling Li, MD 31. Date filed (Month)	Day Year)	32. Registrar's Signa		harris				
Reg		i.co	UN 1 9 2007	Bleeve .	10. 19	and the second				

DHMH 17 Rev 1/2001

07-04489 Richard Jene Oles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

03	11	- 1	17 7	
Lan	U.	. į	97	Lan

			For State		Cert	ificate of	Death			Reg. No.	
Physic	cian		. Decedent's Name (First, Middle,Las	t)					2. Date of Do Month	eath Day Year	3. Time of Death
ledical Exar	mine	er	Richard Gene	e Oles				_	June 11	, 2007	2252 TIFS
		4	a. Facility Name (if not institution, giv	e street and numbe	er)	4	b. City, Town, or	Location of	Death	4c. County of	
		н	Franklin Square Hospital				Rosedale			Baltimore	
Funera	al	- 5	5. Social Security Number 6. Se	7. A	Nge (In yrs. las	st birthday)	If Under 1 Yea			Birth(MM/DD/YYYY)	Birthplace (State or Foreign
Directo	or		218-72-8765 1X	M 2 F	49	Yrs	Months Day	s Hours	Min. Dec.	25, 1957	CountryMaryland
			Jsual Residence of Decedent								
any			0a. State 10b. County		10c. City,	Town or Locat	on				10d. Inside City Limits
pu show	eg .	<u>.</u>	Maryland Bal	timore	1		Balt:	imore			1 Yes 2 X No
Maryland 28a-f show	ator	뚨	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	at Country?
he M	notified at once	Director	9206 Cornflower	Road			21	236		U.S	5. A.
with 1	o lo		11. Marital Status	12. Was Decede			s Decedent of His	spanic Origi	n? (Specify Yes or		- American Indian, Black,
leath item	inst t	Funeral	1 Never Married 2 X Married	Armed Force	s? 2 X No	If Y	es, specify Cubar	n, Mexican,	Puerto Rican, etc.)	White	, etc.
fter d	ı ler	by F	3 Widowed 4 Divorced	If Yes, Give Year	- 11	1	Yes 2 X No	specify:		Specify:	White
ours a			15. Decedent's Education (Specify o	nly highest grade c	ompleted)		nt's Usual Occupa			16b. Kind of Bus	siness/Industry
72 ho	[]	ompleted	Elementary/Secondary (0-12)	College (1-4 c	or 5+)						
036 rithin 72 sne.	Jedio	티		4		Sof	tware En				se Contractor
5-0 led v Hygi	the c	ပ	17. Father's Name (First, Middle, Last)						e, Maiden Surname)	1
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	vent,	8	Bernard A. Oles			T T			len Marie		Chata 7:- Carla
2 C hould hould M. M. M. M. M. M. M. M. M. M. M. M. M.	ı İic	٩	19a. Informant's Name/Relationship (*	Type, Print)						Number, City or Tow	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. tem 27 is marked other than "matural", or items 23a or 28a-f she	anus	L	Jane Oles (Wife) 20a. Method of Disposition		Took F		Cornt Low sition (Name of ce		ad, Balti Date	more, Mar	cyland 21236
ore, s 1 au of Hea	ner tr		1 X Burial 2 Cremation 3	Removal from	State C	rematory or ot	her place)				,
Page Page nent o	or of		4 Donation 5 Other Specify		St.	Josep	h Church	Cem.	06/16/200	7 Baltim	ore, Maryland
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other th	jury	ſ	21. Signature of Surieral Service Lice	nsee	7						Home Inc.
മ ഉള്ള	.E	_	74/6	cela	7	97	05 Belai	r Roa	d, Baltin	ore, Mary	1and 21236
Physicia			23a. Part I. Enter the disease, or comfailure. List only one cause on e	plications that cau's ach line.	ed the death.	Do not enter	the mode of dying	, such as ca	ardiac or respiratory	arrest, snock, or nea	Detween Onset and
/Medic Examin	_	- 1		Atheroscle			cular dis	890			Death
J			or condition resulting in death)	Due to (or as a co	nsequence of	·):					
		_	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	nsequence of	D:					-
		틝	cause. Enter Underlying Cause		113044001100 01	,					
	.=	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence of	f):					
760, Trate be executed physician and			d		T norME	~871 O	/17/07 TT				
760, cate be execut physician and	burial -	/Medical	X UNPENDED	**AMENDED # #23a,27	perME.g	869. 7 <u>/1</u>	0/07 TT				
760, Teate be 3 physici		¥ .	IF FEMALE: 23b, Was decedent pregnant in the	23c. If yes, out	come of pregi	nancy	etal death 3	Fatonia	programmy	23d. Date of Month	f delivery Day Year
	Se -S	ļä.	past 12 months?	1 Live birth	ı t at time of de	ath	etal death 3 other (Specify)	Ectopic	pregnancy	Worten	Day 1001
Box 68 death certif	for	ysic	1 Yes 2 No 9 Unknow			5 C	ither (Specify)				
D. E.	detached	by Physiciar	Part II. Other significant conditions	contributing to de	eath but not re	esulting in the	underlying cause	given in Pa	art I. 23e. D	id tobacco use contr	ribute to the cause of death?
P.O.	e det	희						_	1	Yes 2 ✓ No 3	Probably 4 Unknown
ds, equire	should be d	Completed		-				•	24a. W		Were autopsy findings available
COT law r	CI	흴							р р	erformed?	prior to completion of cause of death?
tal Re tian: The certificate	page	힝						(5		es 2 No 1	Yes 2 No
cian:		Be	25. Was case referred to medical examiner?	Hospital:				Other	(Check only one)	Residence 6	Other:
F Si Physi r this	al dir	۵	1 Yes 2 No 27. Manner of Death	1 Inp		ER/Outpatier 28b. Time of		ury at Work	Nursing Home 5	ibe how injury occur	
∩ of ding P After	funeral	崩	1 Natural 5 Pending	(Month, D	ay,Year)	ZOD. TIMO O	· · · _ ·	Yes 2	,		
SiO!	y the	j a	2 Accident Investiga	tion	f (minum - Ad b					on (Street and Numb	per or Rural Route Number, City
Division of Vital Records, tal or attending Physician: The law require is after death.	filled in by	Certification:	3 Suicide 6 Could no determin	t be	of Injury - At n	ome, tarm, str	eet, factory, office	bullarig, e		vn, State)	rei di Italai Italie Italiber, dily
Divisior Hospital or Attend 24 hours after death Funeral Director:	/ fille	ਲ	4 Homicide	(- an atatad
Division of Vital Records, P.O. Box 68 the Hospital or Attending Physician: The law requires that the death certifully 4 hours after death. The Finneral Director: After this certificate has been signed by the attanding	completely	cal		cian: To the best o er:On the basis of e	if my knowled examination a	ge, death occi ind/or investig	urred at the time, ation, in my opinio	oate ano pi on, death oc	ace, and due to the locurred at the time, o	cause(s) and manne date and place, and	due to the cause(s)
To the within 2	com	Medical		and manner stat				nse number			ned (Month, Day, Year)
		2	29b. Signature and title of certifier	20.1				M.E.		June 12, 2	
			my ow.	/~>						331.3 12, 2	
D			30. Name and address of person who				et, Baltimore	MD 212	201		
				Medical Exami			et, Daitimore	, IVIL 2 12			
	Sta	ate rar	31. Date filed (Month, Day, Year)	32 Kegi	strar's Signat	The state of	and a				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene []

1- For Amend #8, perFH, C868, 6/19/07 TT

Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Vear **Physician** ORLANDO JAMES 3:57 9M 06 07 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CITY BALTIMORE CITY UNIVERSITY OF MARYLAND MEDICAL CENTER If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day 1939 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Min. Days Hours 68 218346842 1 XM 2 ☐ F 114 Washington D C Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show mit: If Item 27 is marked other than "natural", or items 25a or 28a-f show mit: If Item 27 is marked other than "natural be notifiled at my or other traumatic event, the Medical Examiner must be notifiled at 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☐ No Highland **Funeral Director** Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20777 U.S.A. 13036 Deanmar Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: VIETNAM ENA 14. Race - American Indian 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify. White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postal Service Director of Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marion Elizabeth Burch Joseph F. Orlando ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 13036 Deanmar Drive Highland, Maryland 20777 Ms. Christl Orlando Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3 Removal from State 1 ☐ Burial 2 ☐ Cremation 06/13/07 Clarksville, Maryland Department o Important: If any Injury or once. Columbia Memorial Park 4 ☐ Donation 5 Other (Specify) 21. Signal of Fuggeral Service Lig 22. Name and Address of Facility Slack Funeral Home, P.A. M00535 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician FIVE MINUTES disease or condition resulting in death) CEREBRAL HERNIATION /Medical Due to (or as a consequence of) **Examiner** ONE DAY CEREBELLAR STROKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed and bunial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical the ass for use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 🕍 No 24a. Was an autopsy 1□ Yes the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death Certification: Injury (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide determined To the Hospital within 24 hours at To the Funeral C 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. Medical

State Registrar JUN 1 9 9 2007

29b. Signature and title of certifier

Konna

Hertzano, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AU4176435-H17605

29d. Date signed (Month, Day, Year)

OF MARYLAND

6/7/2007

MEDICAL CENTER, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 3: 22 A M Allona 2007 veda une 16. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HilChrist Baltimore 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye
Months Day If Unde Hours 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 18.44.6519 Director August 4, 1946 Maryland Usual Residence of Decede 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at 1 □Yes 2 No Director Kalfimore ilcoville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event. Queenslace Street S.A Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify Black 1 ☐ Yes 2 🔼 No Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Stro Manager Hramask Ind 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Boie hobert Hall mears 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3941 Queenslace Street Pikesville MD Michele Mughkr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 86.21.2007 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene funcial Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8728 Liberty Md Mandael Stown MO Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ears ancer Ovarian /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. the attending physician hed for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy page 2 should be detached for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPLU 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ∏Yes 2 ∏No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) 58303 June 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(170) N. Charles T. Towson W. 21204

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Of No Registrar	iaryiano		tificate of D			eg. No.	157	1973)
	Physicia	an.	Decedent's Name (First, Middle, Last)					Date of Death Month		Year	3. Time of Death
	/Medic	al				4b. City, Town, or L	ocation of Death	June		2007	10:00 P ^M
	Examin	er	4a. Facility Name (If not institution, give street and numbe Genesis Cromwell Center			Parkvi				altimo	ore ,
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 ☒ F 7. A	ge (In yrs. Ia 85			If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 7,	^{Year)} 1921	9. Birthi Cour Mar	place (State or Foreign ntry) 'yland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City Limits
	Maryl -f sho	to	Maryland Baltimore		Par	kville					1 ☐ Yes 2 🌠 No
	th the	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen o		ntry?
	23a cust b	ral	8710 Emge Road			21234				USA ace - Americ	can Indian
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If Item 27 is marked other than "natural"; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced 12. Was Deceder Armed Force 1 □ Yes 2 ▼ If Yes, Give Year or Dates	?] No		Nas Decedent of His f Yes, specify Cuban 1 ☐ Yes 2 No	panic Ongin? (Sp., Mexican, Puerto	ecity Yes of No- Rican, etc.)		lack, White,	
20	72 ho 'natur dical	eted	15. Decedent's Education (Specify only highest grade completed)		(Give	dent's Usual Occupat kind of work done du	ion Iring most of work		16b. Kind of	Business/In	dustry
121	vithin ene. Ihan "	Completed	Elementary/Secondary (0-12) College (1-40	5+)	_	no not use retired) retary			Baltin	more S	Schools
9	filed v Hygie Sther 1		17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, f	Maiden Surn	ame)	
an	and be fental rked c	To Be	John Vachino				Firm	ina Bogg	io		
ary	and N ls ma		19a. Informant's Name/Relationship (Type. Print)			ng Address (Street ar					
S S	and sealth m 27		Mark Peppler, Son	20h Pli		Willoughb			e, Mary		
S S	tges 1 nt of H iffle or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta	e		sition (Name of matory or other place	1 00 /4	- 1		,	Maryland
<u>=</u>	artmer artmer ortant: Injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Met		ematory In Cremation					ralyland
Ba	Depa Impo any ir		21. Signature of Funeral Service Licensee Thomas Gregor			299 Frede	rick Roa	d Baltin	nore,	Maryla	and 21228
			23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death line.	. Do not ent	er the mode of dying	, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	1 10 Ti	6 5	1406/2					1 16727
	/Medical Examiner		resulting in death) Due to (or	s a consequ	ence of):	TMARET	1 d 1 3 = 1	Er 41 00	\		2 1x 1/4 5
8	ar.	-e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	te a coupedn	ence of):	1 1 100 11 20 1	1001	ماسي (ير (م) المراس	2		2 0/17 3
/	outed nd ransit	Examiner	that initiated events c			4-76					
Ö,	e exe yan ar urial-t	I Ex	resulting in death) Last Due to (or	as a consequ	ence of):						
68760,	ificate be executed g physician and as the burial-transit	edical	d								
P.O. Box 6	ath certif attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcomend the point of the point of the past 12 months? 4 □ Pregnan 9 □ Unknown	2 ☐ Fetal at time of de	death 3	□Ectopic pregnancy □ Other <i>(specify)</i>				Date of deli Month	very Day Year
	uires that the de signed by the Id be detached	Completed by Ph	Part II. Other significant conditions contributing to deat		Ilting in the u	inderlying cause give	n in Part I.				the cause of death? obably 4 @Unknown
S	w require been si should t	lete						24a. Was a		b. Were au	topsy findings available ompletion of cause of
æ	ilan: The lar	mo				· ·		perfor	med2 2 No	death?	2 □ No
ita		Be C	25. Was case referred to medical examiner?			la:	26. Place of Dea				
or Vital Records,	Physician: r this certifica ral director, I	မ	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inp		ER/Outpatie		r: 4 Nursing H	ome 5 Resid			eify)
nc	ing After	ion:	1 ☐ Natural 5 ☐ Pending (Month,	Day Year)	Injury	Work	? res 2∐No	Zod. Doodilbo ii	ow injury oo	04.104	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 28e. Place of	injury - At ho etc. <i>(Specif</i>)	me, farm, st	reet, factory, office		28f. Location (S City or Tow	itreet and Nu n, State)	ımber or Ru	ral Route Number,
	e Hospit: 24 hours e Funera etely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the base and manner.	s of examina	wledge, dea tion and/or i	th occurred at the tim nvestigation, in my op	ne, date and place pinion, death occu	, and due to the d rred at the time,	cause(s) and date and pla	d manner as ice, and due	stated. to the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier			29c. License					n, Day, Year)
	,		30. Name and address of person who completed cause			103.	スティテ		15/11	7/ Bee.	* 7
	H		30. Name and address of person who completed cause	of death (Item	23a) (Type	Print) FEMA	and to 1	a. dit	6 12	1	110
			31. Date filed (Month, Day, Year)	a ↑ i Ø istrar's Sign≜	ture	LIVE FILL	15/	77/440	18.45	9112	21234
	St Regist	ate rar	JUN 1 9 2007	41 1	190	see.					

		•	For State Registrar	State of Maryl		tificate of L		Reg.		
4	Physici		1. Decedent's Name (First, Middle, Last) Doris Way Pea	rce				2. Date of Death Month June 15.	Day Year	3. Time of Death 3:50 A M
	/Medic Examin	_	4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of Death		4c. County of Death	10.30 1
94.		ike .	Fairhaven			Sykesvi	ille		Carrol:	L
*	Funeral Director		5. Social Security Number 6. Sex 214-01-6988	7. Age (In)	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Aug. 25,	9. Birth Cou 1917 Ma	place (State or Foreign ntry) ryland
	pu .	1	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	cation				10d, Inside City Limits
	ehor	5	MD Baltimor		Luthervi					1 ☐ Yes 2 ☑ No
	28a-f	ect	10e. Street and Number		CO CHET VI	101. Zip Code		100	. Citizen of What Cou	
	with	급	7 Weston Court			21093		109	USA	
	eath	era	· · · · · · · · · · · · · · · · · · ·	2. Was Decedent Ever	in U.S. 13. \		spanic Origin? (Spe	ecify Yes or No-	14. Race - Ameri	can Indian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Itams 23s or 28s-1 show any injury or other traumatic event, the Madical Exeminal must be notified at once.	by Funeral Director	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2★ No		Rican, etc.)	Black, White	white
Q 2	72 ho	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced	ient's Usual Occupa kind of work done d	ition	ing 16	b. Kind of Business/Ir	ndustry
2	nithin De.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired;			0 - 11	
2	fled w tygien ther th		17. Father's Name (First, Middle, Last)			nemaker	19. Mather's Name	(First, Middle, Ma	Own Hor	ne
anc	ntal H	Be	George S. Way				Ellen C.	, , ,	den Sumame)	
ž	should nd Men marke	၉	19a. Informant's Name/Relationship (Typ	a Printl	10h Mailir	on Address (Street a			City or Town, State, Zi	n Code)
<u>N</u>	d 2 si th an traur		Patricia P. McDon			21 Murkle				
	1 and Health Iem 27		20a. Method of Disposition			sition (Name of natory or other place		and the same of th	c. Location - City or T	own, State
Baltimore,	Pages nent of int: if it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Dogation 5 ☐ Other (Specify)			natory or other place Jalley Mer		9/07	Timonium,	Maryland
불	ortan injur		21. Signal upe of Funeral Service License						Funeral Ho	
Ba	permit. I Departm Importa any inju		Mula 100	2)50 York F			21204	one, inc.
24	Physician /Medical Examiner	ıer	23a. Part. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Preu Due to (or as a cor	monia rsequence of): hiecta		g, such as cardiac o	or respiratory arres		Approximate Interval Between Onset and Death
68760,4	tificate be executed ig physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):					
.O. Box 6	death cer e attendir ed for use	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown	ic. If yes, outcome of pr 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	e ry Day Year
Q.	ad by deta	by Ph	Part II. Other significant conditions conf	nbuting to death but no	t resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
rds	quiras n signa uld be							1 ☐ Yes	27 No 3 ₽ro	bably 4 Unknown
Vital Records,	. The law requiras that the sale has been signad by the page 2 should be detache	Completed						24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of 2 \square No
/ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					h (Check only one)		
	Physician: r this certific ral director,	2	1 Yes 2 No		2 ER/Outpatier		4 Nursing Ho		ce 6 □Other (Spec	ify)
Division of	Attending F r death. , ector: After by the funera	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Yea	28b. Time o Injury	Work		28d. Describe how	rinjury occurred	
DIX	ital or Attenors after death		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S)		reet, factory, office		28f. Location (Stre City or Town,	et and Number or Rui State)	ral Route Number,
	To the Hospital or Attending within 24 hours after death To the Funeral Director: After completely filled in by the tuner	ledical	29a. Certifier ix Certifying Phys (Check only 2 Medical Examin one)	ician: To the best of my er: On the basis of exa and manner stated.	/ knowledge, deat mination and/or in	vestigation, in my of	oinion, death occur	red at the time, date	e and place, and due	to the cause(s)
)	To the l within 2 To the l complet	Σ	29b. Signature and title of counter	MD		29c. License			d. Date signed (Month	
	15		30. Name and address of person who con William Tan M.	properties of death 1645	(Item 23a) (Type, Liberty	Print) Road	e Idersbo	us MD	une 15 a	

State Registrar 31. Date filed (Month, Day, Year)
JUN 1 9 2007

39. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician MARILYNI POWERS 13 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BA/TIMORE UNIVERSITY OF MARYLAND MEDICAL CONTIN 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) October 7, 1949 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1□M 2XF Pennsylvania 173-42-5265 57 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ns 23a or 28a-f show must be notified at 1 ☐ Yes 2X No Directo Virginia | Fairfax Alexandria death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 22310 items 23a 4704 Lillian Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after d nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Iten ury or other traumatic event, the Medical Examiner. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ Caucasian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Special Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Tauscher Marion Davis ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4704 Lillian Dr. Alexandria, VA 22310 Daniel W. Powers - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State June 15, 2007 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 22. Name and Address of Facility Jefferson Funeral Chapel 21. Signature of Funeral Service Licensee 5755 Castlewellan Dr. Alexandria, VA 22315 Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, dk, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease of condition resulting in death) WEEKS ANDIDA **Physician** /Medical Due to (or as a consequence of): Examiner Acute Mye if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 6'3 Division or Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

State Registrar

one)

29b. Signature and title of certifier

ZARBALIAN KLARASH 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

SOUTH GREEN ST. BALT, MONE, MD. 21201 325 Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

07-04633 Robert Phillips

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1- For State 3. Time of Death 2. Date of Death Registrar 1. Decedent's Name (First, Middle,Last) Year Month Day June 17, 2007 1557 hrs hysician/ Michael Phillips Robert Mè. Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore University Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex Foreian 5. Social Security Number Months Days Hours **Funeral** Country) NJ 1954 June 4. 151-50-6781 53 Director 1 X M 2 10d, Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State Yes 2 Y No Mt. Airv Carrol1 MD 28a-f show or items 23a or 28a-f show must be notified at once. 10g. Citizen of What Country? death with the Maryland 10f, Zip Code Director 10e. Street and Number USA 21771 2639 Leslie Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S White, etc. Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces 1 Never Married 2 X Married 2 X No Yes Specify: White Yes 2 X No specify: Yes, Give Year permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or injury or other traumatic event, the <u>Medical Examiner m</u> 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done þ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Social Security Computer Programmer 4 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Loretta Brownholtz Robert Phillips Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 2639 Leslie Road Mt. Airy, MD 21771 Mrs. Bernadette Phillips (Wife) 8 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Baltimore. Burial 2 X Cremation 3 Removal from State Baltimore, MD 6/19/2007 Metro Crematory Donation 5 Other Specify: Haight Funeral Home & Chapel (Box 195) Sykesville, MD 21784 22. Name and Address of Facility 21. Signature of Funeral Service Lig 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and ₁ysician Death failure. List only one cause on each /Medical a. Multiple Injuries Immediate Cause (Final disease Examiner Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Records, P.O. Box 68760, The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED ned by the attending physician detached for use as the burial 23d. Date of delivery 23c. If yes, outcome of pregnancy Year IF FEMALE: Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the past 12 months? Fetal death Live birth 2 Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed be deta þ 24b. Were autopsy findings available 24a. Was an Completed prior to completion of cause of Records, autopsy been death? performed' icate has b page 2 sh ✓ Yes 2 1 🗸 Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: hin 24 hours after death. Nursing Home 5 Residence 6 Other: Division of Vital Other, Be DOA examiner? Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 28d. Describe how injury occurred his 1 🗸 Yes 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day Year) Jun 15, 2007 Passenger auto auto collision 27. Manner of Death After Certification: 2234 hrs Yes 2 ✔ No Natural Pending 28f. Location (Street and Number or Rural Route Number, City Funeral Director: tely filled in by the Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2 🗸 Accident or Town, State) Littlestown Pike at John Owings Road, Westminster, MD Could not be 3 Suicide (Specify) Major Road / Highway determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Homicide 29a. Certifier 1 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 18, 2007 O.C.M.E.

111 Penn Street, Baltimore, MD 21201

ORIGINAL

OCME

Registra

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD. 31. Date filed (Month, Day, Year)

JUN 1

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.4-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ϊ7 2:45a. M 6 20Ó7 Charles Ouarles, Jr. Kevin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Genesis-Long Green 8. Date of Birth (Month, Day, Year) 2 3 1985 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 14EM 2□ F Months Days Hours MD 22 **Director** 215-08-0581 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "naturai", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1XYes 2 No Director N/A MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 21202 USA 301 1720 St. Paul Street Apt. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X N**o If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2€ No Specify Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) n and Mental Hygiene. College (1-4or 5+) NIA 9th N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Angela Myers C. Quarles, Sr. ပ Kevin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: if item 27 is any Injury or other trau 4548 Hazelwood Avenue Baltimore, MD 21206 Demetra Ouarles-sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from State MD 6/21/2007 Mt. Zion Cemetery Baltimore 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME-EAST Wa 1101 E. North Avenue Baltimore, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cau — on eacl wine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical eque of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed the burial-trar and P.O. Box 68760, physician attending properties of the second IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be del Records, Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Upknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an certificate Division or Vital Yes Hospitai or Attending Physician: funeral director, 25. Was case referred examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manne of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 w atural 5 ☐ Pending investigation nours after death. Ineral Director: Af 1 ☐ Yes 2 Accident 6 □ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determin 4 Homicide within 24 hours at To the Funeral C completely filled it 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

29b. Signature and title of certifier

30. Name and addre

31. Date filed (Month, Day,

of person

the

DHMH 17 Rev 1/2001

Item 23a) (Type, Print

29c. License number

29d. Date signed (Month, Day, Year)

10

and manner stated.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nd. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 212M /Medical 2007 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Gevera If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex last birthday Funeral Days 1 M 2 M 5-40-6876 June 20. Director Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside Çity Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Dres 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surgame) Be lia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blackman amara 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 6-22-07 Lansdowne 4 ☐ Donation 7 5 ☐ Other (Specify) 22. Name and Address of Facility 270 Fred HILTON 21. Signatur of Funeral Service Lic-Tuneral 23a, Pat1 In er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, heart failure. List only one cause on each line.

Immediate cause (Final disease in condition resulting in death)

a.

Due to (or as a consequence of the condition of Approximate Interval Between Onset and Death Physician hour /Medical Due to (or as a consequence of Examiner 2000000 you i if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-trar Due to (or as a consequence of): the attending physician Physician/Medical as the IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 20 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.
To the Funeral Director: After this certificate has i completely filled in by the funeral director, page 2 sompletely filled in by the funeral director, page 2 s Division or Vital 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To 1 Inpatient 2 R/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1714 Echw 21217 31. Date filed (Month, Day, Year) egistrar's Signature State JUN 19

DHMH 17 Rev 1/2001

Registrar

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2007 Noon Month **Physician** June 17, RUHLING ELIZABETH MARY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town, or Location of Death Examiner N/A 1706 Johnson Street Baltimore 8. Date of Birth (Month, Day, Year) March 20,1927 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 ☐ M 2 🛣 F 80 Maryland 218-22-6207 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County Baltimore N/A 1 MYes 2 No Maryland Director 10g. Citizen of What Country? U.S.A. 10f. Zip Code 21230 10e. Street and Number 1706 Johnson Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 □ Never Married 2 M Married Specify: White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 à 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Deering Kathryn James Η. Meyers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1706 Johnson Street, Baltimore, Maryland 21230 (Husband) C. Ruhling 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition pormit. Pages
Department of Important: If its
any Injury or o 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Brooklyn Park, Maryland Cedar Hill Cemetery 06 - 21 - 074 □ Donation 5 □ Other (Specify) 21. Signature of F and al Service Lice McCully-Polyniak Funeral Home P.A. 130 East Fort Avenue, Baltimore, Maryland 21230 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed the burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical as for use 23d. Date of delivery 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Year Month Day in the past 12 months? 5 ☐ Other (specify) signed by the a 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2/2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate has 2.23 No 2 No 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Hospital: 22 No 3□ DOA 4 ☐ Nursing Home 5 🗹 Residence 6 ☐ Other (Specify) 1 Tyes 1 Inpatient 2 ☐ ER/Outpatient ပို 28d. Describe how injury occurred 28a. Date of Injury (Month, Day 27. Manner of D ath 28b. Time of Certification: After Injury 5 ☐ Pending investigation 1 Natural M 1 ☐ Yes 2 ☐ No To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

JUN 1 9 2007

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day 2007 **Physician** 07 PM Sylvia K. Rosen June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Astoria II House Columbia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 30, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 □ M 2 🗓 F 76 1930 Pennsylvania 166-26-3767 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 1 ☐ Yes 2 ☐ No Columbia MD Howard Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6636 Cedar Lane 21044 U.S.A. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Typist |Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Benjamin Kaufman Virginia <u>Unknown</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Stark/Son 5604 Friendship Road Halethorpe MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 4 ☐ Conation 5 ☐ Other (3 ☐Removal from State Druid Ridge Cemetery 06-18-2007 Pikesville, Maryland 5 Other (Specify) of Funcial Service License Ambrose funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death therosclerotic (ardiovascular Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 Tyes 2 No 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Hinknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No this certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Group hore 1 ☐ Yes 2 ☐ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) After thi funeral 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Iniury 1 Natural 2 Accident 5 Pending To the Hospital or Attendin within 24 hours effer death. To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No death. investigation 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide or A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 17 2007

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/200

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pamerh Sabapathy 201-109 Back River Neck Road Bathmore Maryland 2/121.

07-04221

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

onel R Roseboi	1	State of Maryland / Department of Health and Mental Hy - For State Certificate of Death		Reg. No. 201	17 1973
Physicia		tegistrar 1. Decedent's Name (First, Middle,Last)	2. Date of Dea	ath Day Year	3. Time of Death
ledical Examir		Lionel R. Roseboro	June 2, 2	007	0241 hrs
	н	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Hospital Center Cheverly		4c. County of Dear Prince Georg	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.		rth(MM/DD/YYYY) 9. B	
Director	L	243-72-4908 1 XM 2 F 62 Yrs.	Octob	er 20 Fore C	ountry) NC
fue fue		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	٦	DC Washington			1 X Yes 2 No
ith the Maryland 23a or 28a-f show notified at once,	Director	10e. Street and Number 10f. Zip Code 20018		10g. Citizen of What Co	untry?
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Intt: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once		645 G. Street SE 20018 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp.	pecify Yes or N	U.S.A.	erican Indian, Black,
eath w items	uneral	1 Never Married 2 X Married 1 Yes 2 X No		White, etc.	
after dal", or	by F.	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify: B1	
hours natur Exami		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use reti	vork done red)	16b. Kind of Business	
hin 72 e. than than this	Completed	8th Laborer		Private	
5-0036 iled within 7 Hygiene. I other than the Medica				Maiden Surname)	
2121 uld be fil Mental I marked r event,	Be	Ulkilowii			te Zin Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Iant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	٩	19a. Informant's Name/Relationship (Type, Print) Duane S. Roseboro - Son 19b. Mailing Address (Street and Number of Four Sour Source) 5043 Sheriff Rd NE	Was	hington D	C 20019
ore, ME as I and 2 s of Health au If item 27	1	20a Method of Disposition 20b. Place of Disposition (Name of cemetery,	_2007	20c. Location - City Beltsvil	or Town, State
MOP Pages nent of ant: If		Bunal 2 X Cremation 3 Removal from State Chesapeak Crematory			•
Baltimore, permit. Pages I an Department of Her Important: If ite	1	21. Signature of Funeral Service Licensee A William Signature of Funeral Service Licensee A William Signature of Funeral Service Licensee 22. Name and Address of Facility Mo 2019 MLK Jr Ave	Laugh , SE,W	lin Funer Jashington	DC 20020
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and
/Medical caminer	1	Immediate Cause (Final disease a. Complications of Chronic Alcoholism			Death
		or condition resulting in death) Due to (or as a consequence of):			
	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause. Enter Underlying Cause			
d Sit	Examiner	(Disease or injury that initiated events resulting in death) Last Use to (or as a consequence of):			
68760, certificate be executed nding physician and se as the burial - transit		d. UNPENDED AMENDED			
60, ate be e hysicia	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliv	ery
tox 6876 eath certificat e attending phy for use as the	jan/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant in the	ancy	Month	Day Year
Box re death c the atten ted for us	Physician/	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown			
och the	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco use contribute	
ords, P.(v requires that s been signed should be dete	ed by		1 Y		autopsy findings available
of Vital Records, ng Physician: The law requir wher this certificate has been s meral director, page 2 should	Completed		aut		o completion of cause of
tal Rec cion: The l certificate l ector, page	Con	OS Plane of Death (Charle		3 2 No 1 🗸	Yes 2 No
Vital ysician: his certifi director,	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other Wurst	ng Home 5	Residence 6 Ot	her:
on of Vital ending Physician: sath. or: After this certifi	1: To	27. Manner of Death 28a. Date of Injury (Month Day Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describ	e how injury occurred	
ion tendir eath. tor: A	atior	1 V Natural 5 Pending 2 Accident Investigation			
Division of 'pital or Attending Phours after death. eral Director: After tilled in by the funeral	Certification:	3 Suicide 6 Could not be determined (Specific)	28f. Location or Town		Rural Route Number, City
		4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and control of the certifying Physician of the certifying Physician of the certifying Physician of the certifying Physician of the certificity of the certif	d due to the ca	use(s) and manner as s	tated.
To the Hos within 24 h To the Fur	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, da	te and place, and due to	the cause(s)
FSFS	Me	29b. \$190 ature and title of certifier 29c. License number		29d. Date signed (/	Month, Day, Year)
		Potri Chonic - Foller is O.C.M.E.		June 4, 2007	
-		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimo	re, MD 212	201	
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Regis	trar	JUN 1 9 2007 Blocker D. April			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ngrdson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Tre care 0/0 Istems W Kandal 056 Mus If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 X F 2-15-1916 072**-**20-4118 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No r 28a-f sh notified Windsor Mill Baltimore MD Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with anent of Health and Mental Hygiene. An ansit if Item 27 is marked other than "natural", or items 23a or any or other thaunatic event, the Medical Examiner must be rury or other traumatic event, the Medical Examiner must be re-USA 21244 8715 Windsor Mill Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give Black, White, etc.
African 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced Year or Dates: American 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Della Alford Roy Alford ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 19a. Informant's Name/Relationship (Type. Print) Tyra Richardson-Byrd/Daught . 8715 Windsor Mill Rd., Windsor Mill, permit. Pages 1 and 2. Department of Health a Important: If Item 27 is any Injury or other trauonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta Crownsville Vet. 6-22-07 Crownsville, MD Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Wylie F/ A P.A. of Balto. Co. 21 Service Licens 9200 Liberty Rd., Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** END STAGE DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner RENAL CHRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed UROLITHIKSIS burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an cate has page 2 s autopsy performed?

1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2₩ No 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? funeral 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director; 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier MO 00061439 2050 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21215 ADEY Emisi 2600 LIBERTY HEIGHTIS ANE, BALTIMORE SOSANYA, m. D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

1 Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N Charles ST Parson no 21204 32 Registrar's Signature 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month **Physician** 9:00 AM June 2007 /Medical 4a. Facility Name (If not institution, give street and humber 4c. County of Death 4b. City. Town, or Location of Death Examiner Howie 1105/106 Cols Howard Count . (ast birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Security Number 215.12.7500 6. Sex 1 ☐ M 2 ☐ F **Funeral** November 7" 1917 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exa<u>miner must be notified at</u> Ellicott City Maryland Howard 1 ☐ Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 3961 Weavers Court 10f. Zip Code 21043 filed within 72 hours after death with 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ ★lo If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ KNo Specify: White Specify. þ 3 Widowed 4 Divorced Be Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) paper goods College (1-4or 5+) millhand Elementary/Segonbary (0-12) 18. Mother's Name (First, Middle, Maiden Surname)
Lydia (unknown) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be 1 nent of Health and Mental I John Ringley ဂ္ 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code)
12 Braided Whip Court Baltimore, Maryland 21244 19a. Informant's Name/Relationship (Type, Print) Ms. Gertrude Dreis Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crest Lawn Memorial Gardens 20c. Location - City or Town, State Marriottsville, Maryland 20a. Method of Disposition Date 06/15/07 1 □ Surial 2 □ Cremation 3 □ Removal from State 4 □ Ponation 5 □ Other (Specify) 22. Name and Address of Facility Home, P.A. of Furthral Service License 3871 Old Columbia Pike Ellicott City, MD 21043 rart1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on, ach line. List only one cause on ach line. mediate Cause (Final sease or condition esulting in death) nesmonia Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending ph for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 res 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:

completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

h

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18im

JUN 1 9 2007

と

31. Date filed (Month, Day, Year,

10724

Little

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** /Medical 4b, City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Days 1 №M 2 ☐ F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene, and the firem 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show unty or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☑Yes 2 ☐ No Director IMOR 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ORE MAN 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) To Be 19b. Mailing Address (Street and Number or/Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20e Location - City or Town, State permit. Pages Department of Important: If ite any Injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1200 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or spi atory arrest shock, or heart failure. List only one cause of h line. Approximate Interval Between Onset and Death Immediate Cause (Final ance Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** mernia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Unsease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit 21 P.O. Box 68760, Completed by Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 4□Pregnant at time of death should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 | Yes 2 1 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Medical Certification: To Be Other: 1 ☐ Yes 200 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Hesidence 6 □Other (Specify) 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

washing 700 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Blud 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

29c. License number 0009644

21215

29d. Date signed (Month, Day, Year)

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2007 8:06 a M June Herbert Α. Stierstorfer 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Baltimore** Gilchrist Center for Hospice Care Towson 6. Sex 1**X** M 2 ☐ F If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number Days Hours JUN 23 1931 213-28-8197 75 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐Yes 2 No MD Lutherville Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21093 USA 2 Kilglass Court, Apt. 102 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Tyes 2 □ No If Yes, Give Year or Dates: Korea 1 ☐ Never Married 2 ▼ Married 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Stee1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Α. Stierstorfer Antoinette Klimic Herbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Margaret K. Stierstorfer - wife 2 Kilgass Court, Apt. 102, Lutherville, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 6/18/2007 Baltimore, MD 21. Signature of Funeral Service Licensee H. Williams Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hear Dalmonary 665Nocine Chronic disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 State (Specify) WSPLO 1 Yes 2 No 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? 1 □ Naturai 5 ☐ Pending investigation 1 ☐ Yes 2 No in bathroom Jule 1 2007 Accident

/Medical Examiner

iny injury or

Physician

/Medical

Examiner

Funeral Director

Completed by

Be

2

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "

death with the Maryland

Maryland 21215-0036

Baltimore,

Sherstorte

or Vital Records,

2007

Physician

Examine

Completed by Physician/Medical

Be

Certification: To

Medical

State Registrar 4 Homicide

29a, Certifier

certificate this

nours after death.

neral Director: After this

filled in by the funeral di

To the Hospital within 24 hours a To the Funeral C completely filled

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifler

6 ☐ Could not be

determined

29c. License number 58303

Namertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Kilgrass Ct. Tinonim, us

30. Name and address of person who completed cause of death (Item, 23a) (Type, Print) wy 6701

tome

31. Date filed (Month, Day, Year)

Charles St Towson NO 21204 32. Jegistrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 16,^{Day}2007 9:57 Physician Faith Hagan Snell June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore 203 Sipple Avenue Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Y Mar. 15, 5. Social Security Number 215-26-4317 9. Birthplace (State or Foreign 6. Sex Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕇 F Maryland 76 931 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City. Town or Location 10a. State 10d. Inside City Limits MD 1 Yes 2 No Baltimore Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 203 Sipple Avenue 21236 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) At Home Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell Hagan Bernadine Thompson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jasper Snell-spouse Sipple Avenue-Baltimore, Maryland 21236 203 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of $6-22^{Date}$ 20c. Location - City or Town, State Moreland Memorial Park Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 8800 Harford Road Parkville, Maryland 21234 21. Signature of Funeral Service Licensee Forder LME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Jon Small **Physician** month resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2□No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident (Month, Day Year) Injury 5 □ Pending investigation 1 □ Yes 2 □ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760,

State Registrar (Check only

30. Name and

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

OVK

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JUNE 13^{Day} MAXIE SUSKI 2007 4:00 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FOREST HILL HEALTH & REHABILITATION FOREST HILL HARFORD If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Manth, Day, Year) Birthplace (State or Foreign Country) 7-03-8160 8017 MARYLAND 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No WD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31016 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: Whit 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BolAr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 6/14/07 Evans Funcial Chapel Belltir 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill dress of Facility Forest HII MOZIOSO. 21. Signatury of Funeral Service tion. vans tureia 23a. Part1. Enter the disease, o shock, or heart fallure. List e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy 1□ Yes coronene 25. Was case referred to me wal examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation

Physician: The law requires that the death certificate be executed the burial-tran Box 68760, signed by the a d be detached t P.0. Division or Vital Records, page 2 the funeral director After this

Physician

/Medical

Examiner

Funeral

Director

2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

traumatic event,

permit. Peges 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic evente.

Physician

/Medical

Examiner

Funeral Director

Completed by

Be

ပ

Physician/Medical þ Completed Be Medical Certification: To

Examiner

within 24 hours a completely State

Hospital or Attending

after death.

filled in by

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAVID DUNN - 615 W. MACPHAIL ROAD - BEL AIR, MD 21014 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

6 ☐ Could not be

JUN 1 9 2007

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

34 Registrar's Signature

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D32295

28f. Location (Street and Number or Rural Route Number, City or Town, State)

JUNE

29d. Date signed (Month, Day, Year)

14 7007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registr Amend #2&8 Per Phy&FH G869 7/02/07/call of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Jun Day 18 2007 **Physician** 1928 0118 Virginia B. Stetka /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 8. Date of Birth (Month, Day, Year) Upper Chesapeake Hospital Bel Air Harford If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□M 2<mark>M</mark>F Days Months 78 Pennsylvania Director 213-28-3698 Dec. 22-1928 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylau Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 X No Director Maryland Harford Forest Hill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 115 Forest Valley Drive 21050 U.S.A. Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Specify: White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alexander MacBlane Martha Weaver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bill Stetka (Son) 633 S. Atwood Rd Bel Air, MD 21014 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐Removal from State 06-21-2007 Bel Air, Maryland Bel Air Memorial Gar. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature | Fine | Se to 1 | Se to 1 22. Name and Address of Facility Schimunek Funeral Home of Bel Air Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RIGHT CARCINOMA **Physician** SMAL /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a some squence of) Examiner burial-trar Due to (or as a consequence of): death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by DBSTRUCTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has , page 2 autopsy performed 2 No certificate 1☐ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death Check onl one director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ▼ER/Outpatient 3 ☐ DOA ၉ After th funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: ospital or Attending hours after death. 5 Pending investigation 1 Natural within 24 hours are control to the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D25017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH AVE BEL AIR 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 15 2007 12:55A Jean C. Schumacher June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Hospital Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/21/1913 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 93 216-05-8752 VA Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show of all Examiner must be notified at MDHarford Bel Air 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1402 Hardley Court 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XXXNo Specify: White Specify: Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Collier Mary E. Thomas ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2. Department of Health a Important: If Item 27 is any injury or other trauonce. Robert Schumacher/Son 1402 Hardley Court, Bel Air, MD, 21014 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a Method of Disposition 1XXX Burial 2 ☐ Cremation 3 ☐ Removal from State 06/22/2001 Parkwood Baltimore, MD 4 □ Donation **∇** ☐ Other (Specify) 21. Signature of uneral Service Licer 22. Name and Address of Facility Ruck Towson Funeral Home Towson, MD, 21204 1050 York Towson, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examiner he law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy eg d perform To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 Inpatient P 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🔼 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar DHMH 17 Rev 1/2001

0

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

M800 4696

H

Box 68760,

Ö

Acher Records, P.

29c. License number

DOG 63770

29d. Date signed (Month, Day, Year)

7007

and manner stated

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 10:00 AM **Physician** 17 JUNE 2007 SAULSBURY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ORTH ROAD 72071/2 FDGFMERE If Under 1 Year | If Under 24 Hrs. BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X**M 2□ F 89 01-28-1918 MD 213-12-3686 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at BALTIMORE EDGEMERE 1 Yes 2 No MD Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21219 7207 1/2 ORTH ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STEEL WORKER BETH STEEL 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental h 1 and 2 should be LENA SAULSBURY JOHN SAULSBURY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other traus ELEANOR SAULSBURY/ DAUGHTER 7207 1/2 ORTH RD. EDGEMERE, MD 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State GARDENS OF FAITH 6/23/07 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licensee BALTIMORE, MARYLAND 21217 1701-31 LAURENS ST. 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ne w Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed burial-trai Due to (or as a consequence of): Box 68760, physician is the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death use 23d. Date of delivery 23h Was decedent pregnant atten for u 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a ☐Yes 2☐No o 9 ☐ Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 Tyes 2.☐No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed

Division or Vital Records, this

or Attending

Hospital

Completed Be P After t Certification: To the nospirate within 24 hours fler death.

To the Funeral Director; A

1∐ Yes 2 -No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 2 No 1 ☐ Yes 27. Manuer of Death

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of (Month, Day Year) 5 Pending investigation

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

29a. Certifier (Check only one)

1 🗹 Natural

2 Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

29c. License number D42102 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) =RO Janes

901 E FOXT QUE MD 21230

State Registrar

Medical

31. Date filed (Month, Day,

6 ☐ Could not be

determined

U/-U462U	07-04620	
----------	----------	--

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Richard Downs Sta	1	- For State	te of Marylan		rtment of tificate of		and M	lental H		211	17 1071.
Physician Medical Examine	/	egistrar I. Decedent's Name (First, Middle	,Last) Richa		wns St				2. Date of Deat Month June 17, 2	Day Year	3. Time of Death 0602 hrs
		a. Facility Name (if not institution 3531 Middleburg Road	_	er)	4	b. City, Tow Union E		ation of Death	1	4c. County of Dea	ith
Funeral Director		216 20 0222	5. Sex 7.	Age (In yrs. la	ast birthday) Yrs.	If Under Months	_	Under 24Hrs Hours Mir	s. 8. Date of Bir Sept	th(MM/DD/YYYY) 9. E 20,193 ^{Forg}	Birthplace (State or eign MD country)
м япу	-	Usual Residence of Decedent 10a. State 10b. County MD Ca	rroll	10c. City,	Town or Location		Inio	n Bri	dae		10d. Inside City Limits 1 Yes 2 XXX
r death with the Maryland or items 23a or 28a-f show any must be notified at once.	rector	10e. Street and Number 3531 Middle		3		10f. Zip Co				0g. Citizen of What Co	ountry?
th with the cens 23a of a be notified	era-	11. Marital Status 1 Never Married 2XX Mai	12. Was Deced	ent Ever in U.		Decedent	of Hispani	c Drigin? (S	pecify Yes or No Rican, etc.)		erican Indian, Black,
rs after deatl ural", or ite miner must	<u>}</u>		1 Yes rced If Yes, Give Year or Dates:	2 XXIo	1 1	Yes XX			work done	Specify:	nite s/Industry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mannell Hygiena, and San and San and Important. If items 73's marked other than "natural", or items 23a or 28a-f she injury or other tranmatic event, the Medical Examiner must be notified at once TA Bo Completed by Ermoral Director	Completed	Elementary/Secondary (0-12) Unknown	College (1-4		during mo Gene	st of working ral C	g life. DO Cont	NOT use rel racto	rired)		pendent
215-0036 be filed within 7 mal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, I	^{-ast)} Garlar	nd L.	Stapf	• • •		other's Nam		Maiden Surname)	
MD 21 d 2 should th and Mer n 27 is man	2	19a. Informant's Name/Relationsh Donna Miller			3531	Midd	llebu	irg R	d. Un:	ion Bridg	
Baltimore, permit. Pages lan Department of Hea Important: If ited injury or other tra		20a. Method of Disposition 1 Burial 2 XXremation 4 Donation 5 Other Spe	3 Removal from		Place of Disposi crematory or oth CTO C1	er place) cemat	ory	6	Date / 19/7	1	sville, MD
Balti permit. Departn Importi injury C	1	21 Signature of Funeral Service	ce)see							neral Hon	
Physician /Medical Examiner		23a. Part I. Enter the disease, or of failure. List only one cause of mediate Cause (Final disease)	on each line. a. Intra-pral gun	shot woun	ıd	e mode of o	dying, suc	n as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
	ا ا	or condition resulting in death) Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co								
ed nisit	xamın	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co								
be execut iician and urial - tra	dica.	UNPENDED	d AMENDED								
Box 6876C The death certificate the attending physical for use as the between the control of th	clan/	IF FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkr	4 Pregnan	h It at time of de	2 Fet	tal death ner (Specif)		Ectopic pregn	nancy	23d. Date of deliv	ery Day Year
P.O. Bost that the degreed by the edetached for Device the designed by the property of the pro	2	Part II. Other significant condition	3 DIKHOW		esulting in the u	nderlying ca	ause giver	n in Part I.			to the cause of death?
ing Physician: The law requires that the death certificate After this certificate has been signed by the attending phys tuneral director, page 2 should be deached for use as the bear.	Completed								24a. Was autop perfo	osy prior to ormed? death	
/ital sician:	o Be	25. Was case referred to medical examiner?	Hospital: 1 Inp	atient 2	ER/Outpatient		Oth	Death (Check	only one)	Residence 6 ✔ Ot	ner: Scene
	-1	1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pendi	28a. Date of (Month D Jun 17, 20	Injury	28b. Time of Ir 0520 hrs	njury 28	c. Injury at	Work?	28d. Describe Subject sho	how injury occurred ot self	
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director. completely filled in by the fu	ertification:		not be	of Injury - At he Single Fan	ome, farm, stree	I et, factory, o	ffice build	ing, etc.	or Town, S		Rural Route Number, City
Divi	ledical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exan	niner:On the basis of	examination a	ge, death occur nd/or investigat	red at the tii ion, in my o	me, date a pinion, de	ind place, an ath occurred	d due to the caus	se(s) and manner as s and place, and due to	tated. the cause(s)
To cor	Me Me	29b. Signature and title of certifier	and manner stat	ted.			icense nu			29d. Date signed (#	Month, Day, Year)
1	-	30. Name and address of person	who completed cause				O.C.M.E			June 17, 2007	
Stat		Ling Li, MD Assistar	nt Medical Exami	ner 111	Penn Stree	t, Baltim	pre, MD	21201			

			- For	partment of Health and Me ertificate of Death	7 17 17 7	7750
į.	Physici /Medi		1. Decedent's Name (First, Middle, Last) Lovis William Saffran, JR.		Date of Death Month Day Year June 13 2007	05:02 M
	Examir	er	4a. Facility Name (If not institution, give street and number) Howhar [How is all institution]	4b. City, Town, or Location of Death	Saltimin	
	E Maryland Director saf show tiffied at	Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthde 220−36−2785 1 🖾 M 2 □ F 66 Yrs	Months Days Hours Min.	Date of Birth (Month, Day, Year) 9. Bi	irthplace (State or Foreign Country) MD
Baltimore, Maryland 21215-0036			Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or MD Anne Arundel Glen Bu	rnie		10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	3a or 2	l Dire	10e. Street and Number 5805 Larsen Street	10f. Zip Code 21061	10g. Citizen of What C	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event; the Medical Examiner must be notified at once.	To Be Completed by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri □ Yes 2☑ No Specify:	fy Yes or No- can, etc.) 14. Race - Arr Black, Wh Specify: W	nite, etc.
	within 72 ho ene. than "natur ne Medical I		(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	redent's Usual Occupation re kind of work done during most of working DO NOT use retired) MD State Police Dept.		
	I be filed very that Hygie ed other is event, the		17. Father's Name (First, Middle, Last) Louis William Saffran, Sr.	18. Mother's Name (First, Middle, Maiden Surname)	office Dept.
	2 should and Me is mark raumatic		19a. Informant's Name/Relationship (Type. Print)	ailing Address (Street and Number or Rural	Route Number, City or Town, State	
	Pages 1 and ent of Health it: If Item 27 y or other to		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Discemetery, 6	05 Larsen Street; G1 sposition (Name of rematory or other place) d Vets. Cem. 06-17		or Town, State
Baltir	permit. P Departm Importar any Inju		21 Signature of Funeral Service Licensee	22. Name and Address of Facility Sing 1 Second Ave SW; G1	leton Funeral Ho	ome, PA
Vital Records, P.O. Box 68760, ~	Physician	be Completed by Physician/Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Failme	respiratory arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of): Who -is dwaic Co	whomspleath		anoths.
	te be executed ysician and e burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):			
	ficate be ex physician s the buria		d			
	the death certificate y the attending phys ched for use as the			3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of d Month	delivery Day Year
	ding Physiclan: The law requires that the death certificate n. After this certificate has been signed by the attending phystuneral director, page 2 should be detached for use as the		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death? Probably 4 □Unknown
			j 		24a. Was an autopsy performed? death	
			25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpa	26. Place of Death (tient 3 DOA Other: 4 Nursing Home	Check only one) e 5 ☐ Residence 6 ☐ Other (Sp	nocify)
n o	ding Phy I. After this funeral c	on: To	27. Manner of Death 28a. Date of Injury (Month, Day Year) Injur	e of 28c. Injury at 28 Work?	d. Describe how injury occurred	oedny)
Division or	To the Hospital or Attending Physiclan: within 24 hours after death. To the Funeral Director; After this certifica completely filled in by the funeral director, to	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No me, farm, street, factory, office 28f. Location (Street and Number or Rural Route N City or Town, State)		Rural Route Number,
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dependence on the control of the pasts of examination and/of and manner stated.			
	To th within To th	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo	

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sun Renafici, M.D. 1417 Madish Park Druk Gkn Brain, MO 2106/

31. Date filed (Month, Day, Year) - 32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Delores Smith UNE /Medical 4b. City, Town or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) **Examiner** GLEN BUZNIE BALTIMORE HARHINGTON MEDICAL CENTER If Under 1 Year If Under Months Days Hours 8. Date of Birth (Month, Day, Year) May 12,1928 7. Age (In yrs. last birthday Social Security Number 6. Sex **Funeral** 1 □ M 2 🗓 F 79 MD 216-20-8910 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County Show r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 First Avenue Marley 21060 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛛 No White Baltimore, Maryland 21215-0036 Specify Specify: þ 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygien Important: If Item 27 is marked other than any injury or other traumatio. College (1-4or 5+) Elementary/Secondary (0-12) President Printing 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wiliam C. Piggot Rachel H. Hillyer 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Gail Reilman /Daughter 4302 Kensington Road Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition June 19, 2007 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park Glen Burnie, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Singleton Funeral Home, P.A. 21. Signature of Foneral Service Licensee M01411 1 Second AVenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ completely filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has 1 Yes 25. Was case referred to medical examiner? 1 Yes 2 No Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Many r of Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred After (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

State Registrar

8

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

d address of person who complete cause of teath (Item 23a) (Type, Print

2007

32 egistrar's Signature

DHMH 17 Rev 1/2001

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Glen burnie

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 7:30 ам Oneida Anne Schneider June 14, 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Under 1 Year | If Under 24 Hrs. N/A Joseph Richey Hospital Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours 1 □ M 2 🖫 F 08/15/1924 Director 219-18-9574 82 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show notified at 1 ☐ Yes 2X No Directo MD Baltimore Nottingham 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or Items 23a or 3 Clipstone Court 21236 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louis Kromm Sarah Edna Fantom 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Frederick J. Schneider (Son) 1204 White Mills Road, Catonsville, MD. 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot 1 Burial 2 Cremation 3 Removal from State 06/19/2007 Baltimore National 4 Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Marlit 23a. Part1. Enter the disease, or con shock, or heart failure. List only controls that caused the death. Do not enter the mode of dying. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical consequence of): Examiner Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine attending physician and for use as the burial-transi The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month in the past 12 months? Day 5 ☐ Other (specify) signed by the a □Yes 2□No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of de ? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 □ No ☐ Probably 4 Plnknown Completed 4b. Were autopsy findings available prior to completion of cause of 24a. Was an es 2 No 2 the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one Other: 1 Tyes 2 **1** M6 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA → Nursing Home 5 🗆 Residence 6 Other (Specify) Medical Certification: To Director: After the in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determi 4 Homicide within 24 hours

To the Funeral [1 (Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

DHMH 17 Rev 1/2001

State Registrar

7

07 Sta

-04458 anley Shelton	1	Please Type or Print in Blac State of Maryland / [Departme	ole Ink. Ent of Hea	th and Mental F	-lygiene	20	07 1975
Physicia	F	egistrar Decedent's Name (First, Middle,Last)				Reg. 2. Date of Death		3. Time of Death
"cal Examir	er	Stanley K.	Shelto			Month Di June 11, 200	ay Year)7 4c. County of Dea	0540 hrs
		4a. Facility Name (if not institution, give street and number) 2152 Harman Avenue			Town, or Location of Dea more City	atri	N/A	
Funeral Director			(In yrs. last birth	day) If Und Mont	der 1 Year If Under 24H ns Days Hours M	8. Date of Birth(I	952 9. E	
any		Usual Residence of Decedent 10a. State 10b. County 10	Oc. City, Town o	r Location				10d. Inside City Limits
*	5	Maryland N/A	Balti			11 7.29		1 X Yes 2 No
ith the Maryland 5.23 or 28a-f show a notified at once.	Director	10e. Street and Number 2152 Harman Avenue		1	p Code 21230	10g.	Citizen of What Co	
Baltimore, MD 21215-0036 permit Pages I and 2 should be fited within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be notified at once.	— L	11. Marital Status 1 Never Married 2 Married Forces? 1 Yes 2 X	ver in U.S.	If Yes, spec	lent of Hispanic Origin? (cify Cuban, Mexican, Pue		White, etc.	
s after	호	3 Widowed 4 X Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade complete)	leted) 16a F		2 X No specify:	of work done	Specify: W 6b. Kind of Busines	
72 hour n "natu al Exar	Completed	Elementary/Secondary (0-12) College (1-4 or 5+	d	uring most of w	orking life. DO NOT use r			
within giene.	dwo	8th 17. Father's Name (First, Middle, Last)		Driver	18 Mother's Na	ame (First, Middle, Ma	Cab	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the 11 dica	Be C	Robert Shelton			Be	tty Jones		
MD 21 d 2 should I Ith and Mes n 27 is man	P	19a. Informant's Name/Relationship (Type, Print) Betty Shelton / Mother	196	. Mailing Addre	ss (Street and Number of		er, City or Town, St e, Maryla	
e, M L and 2 Health item 2		20a. Method of Disposition		f Disposition (N	ame of cemetery,	Date	20c. Location - City	or Town, State
Baltimore, permit Pages Lan Department of Hea Important: If Iter		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:	Bayvi	ew Crem	atory 6,	/16/2007		re, Maryland
Balti permit Departu Import		21. Signature of Funeral Service Licensee	· la		nd Address of Facility (Ritchie High	Gonce Fune hway Balt	ral Servi	ce, P.A. ryland 21225
Physician Medical	9	23a. Fart I. Enter the disease, or complications that caused the failure. List only one cause on each line. Immediate Cause (Final disease a. Narcotic (mg		t enter the mod	e of dying, such as cardia			Approximate Interval Between Onset and Death
≟xaminer	П	Immediate Cause (Final disease or condition resulting in death) a. INAICOTIC (IIX) Due to (or as a consection)		DILOXICAL	1011			
	<u>r</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consec	quence of):					
	Examin	(Disease or injury that initiated events resulting in death) Last	quence of):					
executed an and al - transit	-1	d						
18760, rificate be exe	ledic	XUNPENDED AMENDED 7,28c IF FEMALE: 23c. If yes, outcom	a-f, perM	E, g868.	6/26/07 TT		23d. Date of deli	very
Box 68760, e death certificate be execut the attending physician and red for use as the burial - tran	Physician/Medica	23b. Was decedent pregnant in the	2	Fetal dea		egnancy	Month	Day Year
Box death of the atter	nysic	1 Yes 2 No 9 Unknown g Unknown						
ires that the d signed by the		Part II. Other significant conditions contributing to death	but not resultin	g in the underly	ing cause given in Part I.	P******		e to the cause of death? Probably 4 Unknown
ords, F w requires as been sig	eted					24a. Was a autops		e autopsy findings available to completion of cause of
of Vital Records, ng Physician: The law requir Wher this certificate has been s' meral director, page 2 should t	Completed by					perform		
Vital Rec ysician: The l his certificate	Be C	25. Was case referred to medical examiner?			26.Place of Death (Ch			
n of Vit ding Physic After this funeral dire	ပ	1 Yes 2 No Inpatier 27. Manner of Death 28a. Date of Injur	ıry 28b.	utpatient 3 Time of Injury	DOA Other 4 No		Residence 6 COO	other: Scene
ion of tending Pl eath. or: After the funera	ation	1 Natural 5 Pending FMD 6/11/	ear)	D 5:30 an	1 Yes 2 X No	unk		
Division pital or Attendir ours after death. leral Director: A	Certification:	3 Suicide 6 X Could not be 28e. Place of Inj		arm, street, fact	ory, office building, etc.	or Town, St	ate)	r Rural Route Number, City
Hospi 4 hou Funer ely fil		4 Homicide determined (Specify) F] 29a. Certifier 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of example of the control of the control of the basis of example of the control of the basis of example of the control of the basis of example of the control of the basis of example of the control of the basis of example of the control of the basis of example of the control of the basis of example of the control of the basis of example of the control of the basis of example of the control of the basis of example of the control of the basis of example of the control of the basis of example of the control of the basis of example of the control of the basis of example of the basis of example of the control of the basis of example of the basis of the basis of example of the basis of example of the basis of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of e	v knowledge, de	ath occurred at	the time, date and place, my opinion, death occur	, and due to the cause	e(s) and manner as and place, and due	stated.
To the I within 2 To the I complet	Medical	and manner stated. 29b. Signature and title of certifier			29c. License number			(Month, Day, Year)
		10/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/	1	1	O.C.M.E.		June 11, 200	7

State 31. Date filed (Month, Day, Year)
Registrar JUN 1 9 2007

30. Name and address of person who completed cause of death (Item 23a)

Susan Hogan MD. Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician John Whettle Scroggs June 17, 2007 12:28 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carrol1 If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months 1**X** M 2□ Yrs. 85 5, 1921 217-16-5482 Dec. Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Experiment Once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Tyes 2 No Director MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 408 T-2 Shirley Manor Road 21136 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify þ 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Baltimore City Police Detective 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irene В. Unknown Scroggs ဥ Harry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 Dyer Avenue Reisterstown, MDCarol Swigar Daughter 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/21/07 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cem. Pikesville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road hen Eline Funeral Home Reisterstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1 wk neumons /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by cate has been significated be a 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed death? 1 □ Yes 2□ No 1∐ Yes 2 🗷 No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🖂 Inpatient this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) 1 Natural 5 | Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 29a. Certifier 🖎 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number

10+1

State Registrar

31. Date filed (Month, Day,

Year)

DHMH 17 Rev 1/2001

ORIGINAL ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** KOBERT SINGER JUNE 14 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE NORTHWEST HOSPITAL CENTER RANDALLSTOWN 7. Age (In yrs. last birthday)
72 Yrs. If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 09/27/1934 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**X** M 2□ F 215-30-9006 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notifled at 1 ☐ Yes 2√ No Director OWINGS MILLS MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21117 U.S.A. items 23a 10312 CASCADE FALLS COURT Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. þ 3 Widowed 4 Divorced natural", Completed 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within and Mental Hygiene. than. Elementary/Secondary (0-12) College (1-4or 5+) SALES PHARMACEUTICALS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FELDMAN SINGER ANN LOUIS ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is n any Injury or other traum DOROTHY SINGER / WIFE 10312 CASCADE FALLS COURT - OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HAR SINAI CONG. 06/17/2007 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final INTRACTRE ORDE HEMORIL HAGE **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-trar and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant for 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 2 ☐ No ed by the a detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ KIDNEY DIGEAGE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an has autop. performed 2 2 ABDONIIME Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29d. Date signed (Month, Day, Year)

TUME 14 P 2007 29c. License number 29b. Signature and title of certifier DS4288

Registrar

State

DHMH 17 Rev 1/2001

NORTHMEST HUGBITAL CENTUR

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bancowanis

31. Date filed (Month, Day, Year)

Rangerapy

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 7:25 P M JUNE 14 2007 SUREFF **SEYMOUR** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE 2412 DIANA ROAD BALTIMORE if Under 1 Year if Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 06/27/1935 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 71 Yrs. MD 219-30-5467 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2√ No Director BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21209 2412 DIANA ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No WHITE Saltimore, Maryland 21215-0036 þ 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) LAW **ATTORNEY** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RASNIKOFF SUREFF FREDA BENJAMIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) REVA KADEN / SISTER 3506 HUNTERS SOUND - SAN ANTONIO, TX. 78230 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition BETH TIFILOH CONG. 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 06/18/2007 WOODLAWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 8 year **Physician** denocarcinoma /Medical ue to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusity (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE . If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. certificate has been signed irector, page 2 should be det 9 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed: 1□ Yes 2 NO 25. Was case referred to medical examiner? 26. Place of Death Check onl on-Be Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ Ko 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

The Funeral Director: A pletely filled in by the fu 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Propertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hosp within 24 ho To the Fune completely f

State Registrar

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Pay, Year)

Balhmore MD 21231 401 North Broadway, Michael A. Carducci M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death · 2007 Physician 06.12 08 PM /Medical Mable Tate 4a. Facility Name (If not institution, give street and number) Examiner Sidebrook Mad Juny mile er 1 Year If Under 24 Hrs. altimore 8. Date of Birth Month, Day, Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**F Hours Months 187-30-4164 Usual Residence of Decedent Director 10c. City, Town or Location 10b. County 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ Wo Completed by Funeral Director altimore Owings mills 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Sidebrook Moad #308 Pages 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23s 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Blacic 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify 3√2 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) omestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Lauten Glaham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 世 308 Willard Clayton Ousings mills maguit Nephew 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 ☑ Burial 2 □ Cremation 3 □ Removal from State Ucy Clo. 19.207 Ambler DA
22. Name and Address of Facility aughn C. Grecike June 12. 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Vaugha C 8728 Liberry And Mandallstown mo 21133 23a. Part1. Ented the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Montas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending p 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TS/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 24

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) JUN 1 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D26394

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	Otato of Ivi	ai yiai ic		rtificate of		a WICITE	Reg. 1	20117	10	175
	Physici	an	1. Decedent's Name (First, Middle	, Last)					2. Dat Mo	e of Death nth [JUNE]	la, 2007		e of Death
	/Media	cal	Edwin Thate 4a. Facility Name (If not institution)	aive street and number)			4b. City. Town.	or Location of De			4c. County of Deat		SØ AM
	Examin	ier	Saint Josep		Cent	er	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		son			imor	, e
	Funeral			6. Sex 7. Ag		ast birthday) Yrs.	If Under 1 Year Months Days		in. (Mo	e of Birth onth, Day, Yea	11) (0)	intrv)	te or Foreign
	Director		494-14-4186 Usual Residence of Decedent	71	89	110.			μ5-1	14-1918	Miss	ouri	
	rylanc thow	_	10a. State 10b. County		10c. City,	Town or Lo	cation						City Limits
	he Ma 8a-f s	Director	Maryland Balti	more	Ва	altimo	_			1			′es 2 □ No
	with the or 2 to be no	Ö	10e. Street and Number 5101 Holder Ave				10f. Zip Code 21214			_	Citizen of What Co	intry?	
	ms 23	Funeral	11. Marital Status		Ever in U.S	3. 13.	Was Decedent of If Yes, specify Cu		(Specify Ye		14. Race - Amer		
-000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Mam 3 ☐ Widowed 4 🎇 Divorced	12. Was Decedent Armed Forces? ed 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No		1 □ Yes 2X No		ieno Rican,	etc.)	Black, White		
ה ה	"natu	etec	15. Decedent (Specify only highes	's Education it grade completed)	I	16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation during most of	working	16b.	Kind of Business/I	ndustry	
7 7	within ene. than he Me	Completed	Elementary/Secondary (0-12)	College (1-4or s	5+)	Sales		ed)		Pa	rkwood C	emete	rv
2	offled other ent, t	Be	17. Father's Name (First, Middle, I	Last)				18. Mother's N	Name (First,				
Jana	ould be Menta arked atic ev	ToB	Frederick Thate					Emma S	tepher	ıs			
Mar	12 sho		19a. Informant's Name/Relationsh	-							y or Town, State, Z	ip Code)	
บั	1 and Health em 27 ther t	: 5	Rodger Thate (S	on)	20b. Pla	ace of Disno	Red Clovesition (Name of		arkvi] Date		21234 Location - City or	own State	
2	Pages nent of I int: If ite		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			-	natory or other pl Cemeter		20-20		ltimore,		
altillion	mit. F partme sortan / Injur		21. Signature of Funeral Service I		1.42						eral Hom		and
<u> </u>	permi Depa Impo any Ir		Stefan	eo Rina	Re		05 Belai						
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each li	the death. ne.	. Do not ent	er the mode of dy	ring, such as card	diac or respi	ratory arrest,			nate Between nd Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a SEPTIO								Oliseral	To Douth
	Examiner			Due to (or as INFECT			L DECUI	BITUS					
		ner	Sequentially list conditions, in any, reasoning to immediate cause. Enter Underlying Cause (Disease or injury that light the party in the cause)	b. Due to (or as	а сопвеци	anda bilje							
/	ecute and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	0.000000000	2222 25):							
00/00	be exician a		3	Due to (or as	a consequ	ence oi):							
000	rtificate be executed ng physician and as the burial-transit	Medical		d									
200	ith cert tendin rr use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 □Live birth	pf pregnar	ncy death 3[∃Ectopic pregnan	cv			23d. Date of deli	-	
9	ne dea the at hed fo	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of de	ath 5	Other (specify)	-,			Month	Day	Year
Ċ	that the ed by detac		Part II. Other significant condition	ons contributing to death b	ut not resul	ting in the u	nderlying cause g	iven in Part I.	23	e. Did tobacc	o use contribute to	the cause	of death?
colds,	quires n sign ald be	d by	PARKINSON'S DI	SEASE						1 ☐ Yes	2 No 3 □ Pro	bably 4	□Unknown
2	aw rec s bee 2 shou	Completed							24	a. Was an	24b. Were au	opsy findin	gs available
č	The I ate ha page	Com							_	autopsy performed Yes 2	24b. Were au prior to c death? No 1 \(\sum Yes	ompletion o	if cause of
V	iclan: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:				26. Place of [Death (Chec				
5	Phys r this ral dir	<u>.</u>	1 ☐ Yes 2 (No 27. Manner of Death	28a. Date of Inju		R/Outpatier 28b. Time o	IL 3 DOA				6 □Other (Speciality)	ify)	
5	nding th. :: Afte e fune	tion	1 Natural 5 ☐ Pending 2 Accident investig	g (Month, Da	y Year)	Injury	W	ork? ☐Yes 2 ☐ No	200. 00	Sonbe now ii	ijury occurred		
	al or Atter after dea I Director d in by the	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		ury - At hor c. (Specify)	me, farm, str	eet, factory, office		28f. Loc Cit	cation (Street y or Town, St	and Number or Ru ate)	ral Route N	lumber,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier 1 Certifying (Check only one) 1 Medical f	g Physician: To the best Examiner: On the basis o and manner st	f examinati	vledge, deat ion and/or in	h occurred at the vestigation, in my	time, date and pl opinion, death o	ace, and du	e to the cause ne time, date	e(s) and manner as and place, and due	stated. to the caus	se(s)
	To the within To the comp	M	29b. Signature and title of certifier	In Pro	121	ie m		se number		29d. 1	Date signed (Month	, Day, Year	7
	10		30. Name and addless of person	who completed cause of d	eath (Item	23a) (Type,	Print)						
			JOGINDER FO.	MEHTA, M.			01 OSLE	ER DRIV	E T	DWSON	MARYLA	AND	2120
	Sta Registr		31. Date filed (Month, Day, Year)	9 2007 (2008t)	u o orgitali	K	hout!						
DHN	MH 17 Rev 1/2	4			4000	~ /							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 June 11, 2:15 PM Dot Regina Ventura 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Gilchrist Hospice Center Towson 8. Date of Birth Month, Day, Year, NOV. 7, 1926 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Months Virginia 214-24-0530 80 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 No MD Baltimore Phoenix 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21131 United States 13710 Harcum Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14 Bace - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 🛣 No Specify 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accounting Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marious C. Gibson Edith Lumpkin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Karen Flower, Daughter 613 Oak Farm Court, Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State Dulaney Valley Memorial Cdns. 06/14/2007 Timonium, Maryland 4 Donation 5 A Other (Specify) Enternment 22. Name and Address of Facility Brian T. Chisholm Funeral Services of ce Licensee M01113 Dulaney Valley, P.A. 200 Padonia Road, Timonium, MD 21093 23a. Part1. Enter tile disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interval Between Onset and Death - AryngOAL CANCER - metastatic Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed2 (es 2 No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation

Physician /Medical Examiner

The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

ral", or Items 23a or 28a√f show Examiner must be notified at

2 should be filed within 72 hours after and Mental Hygiene.

permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any Injury or other traun

other traumatic event, the Medical

Balfimore, Maryland 21215-0036

68760

Box

o

۵

Records,

Vital

5

Division

or Attending Physician:

the Hospital

Director

Funeral

þ

Completed

Be

မ

Examiner Physician/Medical

signed by the attending physician be detached for use as the burial has been page funeral director,

Completed by Be Medical Certification: To

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

certificate this death. within 24 hours after deat To the Funeral Director: filled in by To the Fune completely fi

> 20 State

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) June 11, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 A. R. Ley GBMC 6701 N. Churles St. Bolto Md 21205

Registrar

Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** June 16 2007 Vaughan-Bennett Betty Mae /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Gilchrist Center for Hospice Care Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours Min. 1 ☐ M 2 🗶 F SEP 29 1947 59 Maryland 213-52-8987 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Baltimore Hunt Valley 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 21030 USA 1427 Shawan Road Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23. Iny or other traumatic event, the Medical Examiner must 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 Specify: Specify White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own_Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thompson Ethe1 Marie ٩ Frederick James Morrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1427 Shawan Road, Hunt Valley, Maryland 21030 Bernard A. Bennett - husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages:
Department of H
Important: If ite
any injury or of 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 6/18/2007 Baltimore, MD 21. Signature of Funeral Service Licensee H. Williams 22. Name and Address of Facility Cremation Society of Maryland, Inc. nel 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pancreatic Physician ance ews /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) 4□Pregnant at time of death the 9∏Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 I No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed: Yes 21 has 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: MUSPLL 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 Inpatient 2 nours after death.

neral Director: After this
filled in by the funeral d 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c License number 29h Signature and title of certifier

State Registrar harles

TOW SUN MA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 13,2007 Gisela H. Vorke **Physician** June 7:20 PM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) County of Death Baltimore **Examiner** Towson Gilchrist Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 213-36-9400 1 □ M 2 🗶 F 76 Yrs. Nov. 30, 1930 Selesia, Poland Director Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Harford Bel Air MD 1 ☐ Yes 2 No Director 10f. Zip Code 21015 10g. Citizen of What Country? 10e Street and Number of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be r USA 205 Burkwood Ct. Unit B Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iter any Injury or other traumatic event, the Medical Examiner 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 🌠 No Specify: Specify: Polish δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) N/A Environmental Elementary/Secondary (0-12) Assembler 12 17. Father's Name (First, Middle, Last) Alfred Grunnert 18. Mother's Name (First, Middle, Maiden Surname) Helena Hornia Be ဥ 19a. Informant's Name/Relationship (Type. Print) Edward Vorke- Spouse 19b. Mailing Address (Street and Number of Rural Route Number, City of Town, State Zin Code) 205 Burkwood Ct. Unit B Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Funeral Chapel 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Forest Hill,MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name an Ewans of Funeral Chapel & Cremation Services Bel Air 3 Newport Dr. Forest Hill, MD 21050 andral Fadol 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ancek **Physician** nonths /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Be Completed Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Directors. After this certificate has been signed by the attending physician and 'completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

			24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical		26. Place of Death (C	heck only one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 Nursing Home	5 ☐ Residence 6	S Gother (Specify)
27. Manner of Death 1 Matural 5 □ Pending 2 □ Accident investigatio	(Month, Day Year) Injury		. Describe how injury	
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ffice 28f.	Location (Street and City or Town, State)	d Number or Rural Route Number,)
	hysician: To the best of my knowledge, death occurred at the			

31. Date filed (Month, Day,

and manner stated.

29b. Signature and title of certified

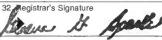
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles St. Balts Md Z120x GBM(6701 K.ley

State Registrar

Medical



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month JUNE Day **Physician** Faye Varlas 18, 2007 12:30FM /Medical 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) . 1917 **Funeral** Months Days Hours Min. 1 □ M 2 ▼ F 218-48-0575 90 **Director** Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 X No Director MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 USA 2 Southerly Court, #104 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23s any Injury or other traumatic event, the Menteral Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Polites Mary Maris ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 Stanley N. Varlas/Son 8 Norwick Cr., Timonium, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 06/21/2007 4 Donation 5 Dother (Specify) Demetrios Cub Hill, MD 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Signature of Funeral Service Licensee 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition INTRACRANIAL HEMORRHAGE **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, 12 ling 1 limm claticause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse juence of) Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 D No Day 4 ☐ Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 → No 24a. Was an autopsy performe 1□ Yes 2√ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 4 Homicide determined

spital or Attending Physician: The law requires that the death certificate be executed ours after death.

In a law of the attending physician and filled in by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760, To the Hospital o within 24 hours aft To the Funeral Di

Baltimore, Maryland 21215-0036

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

M-ehla

29c. License number D41410

29d. Date signed (Month, Day, Year) 200

MARYLAND 21204

TOWSON.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOGINDER P. MEHTA

31. Date filed (Month, Day, Year)

M. D. 7601 32. Registrar's Signature

OSLER DRIVE

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Year **GEORGE** WATSON JR. С. 1200 /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Washington Med. Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day,
Oct. 21 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months 1 M M 2 □ F 77 214-24-6814 Maryland 1929 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State 28a-f show notified at 1 ☐ Yes 2 X No Anne Arundel Pasadena Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Exa<u>miner must be a</u> U.S.A. 9193 Rolling Meadow Run 21122 Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ò 3 Midowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Johns Hopkins, Applied Elementary/Secondary (0-12) College (1-4or 5+) Physic's Lab 12 0 Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi Rhodes George C. Watson Sr. Norma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important; If item 27 Is n any Injury or other traum 161 Highfield Road, Ainille, Pennsylvania 17302 George C. Watson III (son) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park Cem. Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 06-21-07 Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A.
3204 Mountain Road, Pasadena, Mary 21. Signature of Funeral Service License Maryland 21122 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner s certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IE FEMALE If yes, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 2 | Fetal death in the past 12 months? 1☐ Yes 2 🗷 No Month Dav Year 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was a. autopsy performe 21 No 1∐ Yes 1 Yes or Attending Physician: uneral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 ipatient 2 ☐ ER/Outpatient 3□ DOA Medical Certification: To this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death within 24 hours after death.

To the Funeral Director: After completely filled in by the funera (Month. Day Year) Injury 1 atural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier r: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) X 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Month Day Year **Physician** Margaret Marie Wilkens June 16, 2007 2:15 PM /Medical 4a. Facility Name (If not institution, give street and number)
Mariner Health of Belair 4c. County of Death 4b. City, Town, or Location of Death Examiner Belair Harford If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, February 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 12, 1908 Mary Tand 1 □ M 2**√x**F 212-30-9516 99 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County "natural", or items 23a or 28a-f show edical Examiner must be notified at Mary land Baltimore N/A 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 155 S. Grundy St. Apt. 128 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2KNo Specify: Completed by 3 X Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 hc
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natur
any injury or other traumatic event, the Medical B
once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesperson Hecht Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Reilly Margaret Baker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald T. Robinson-Son 3721 Hudson Street Baltimore Maryland 21224 20b. Place of Disposition (Name of cemeters, crematery or other place)
Most Holy Redeemer 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 6/20/07 Baltimore Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck 5305 Hartord Road Baltimore Maryland hustina Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Immediate Cause (Final disease or condition resulting in death) **Physician** er /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner al or Attending Physician: The law requires that the death certificate be executed safter death.

I Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: ဥ 1 ☐ Yes 2 No Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Iniury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D56545 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHILPI KHOSH 206 HAYS ST# 102 BEL AIR, MD 21014

31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Of Ma		artment of Health and M rtificate of Death		giene Reg. No.2007	19765
F	Physicia	an	Decedent's Name (First, Middle, Last) ZIGMUND S	WASKIEV	TC7	2. Date of Dea Month JUNE	Day Year 15 2007	3. Time of Death 8:30 p ^M
	/Medic		4a. Facility Name (If not institution, give street and number)	WADKIEV	4b. City, Town, or Location of Death	DONE	4c. County of Death	0.30 p
Ē.	Examin	er	108 KENNARD AVENUE		EDGEWOOD		HARFORE	
	Funeral			e (In yrs. last birthday)		8. Date of Birtl (Month, Da)	h 9. Birthp	place (State or Foreign
k	Director		168 12 8549 Usual Residence of Decedent	8 4 Yrs.		3/7/1	923 MASS	ACHUSETTS
	/land ow at		10a. State 10b. County	10c. City, Town or Lo	ocation			0d. Inside City Limits
	a-f sh	ctor	MD HARFORD	EDGEWO	OOD			1 □ Yes 2 No
	or 28	Dire	10e. Street and Number		10f. Zip Code		10g. Citizen of What Cou	ntry?
	s 23a	ral	108 KENNARD AVENUE	Super in ILS 42	21040	noify Von or No	USA 14. Race - Americ	ean Indian
36	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2√ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent: Armed Forces? 1 □ Yes 2 □ If Yes, Give Year or Dates:	WW II	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	Rican, etc.)	Black, White, Specify: WHI	etc.
15-0036	"natural	Completed t	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation k kind of work done during most of work DO NOT use retired)	ing	16b. Kind of Business/In	dustry
2121	within iene. • than "!	dmo	Elementary/Secondary (0-12) College (1-4or 5	5+)	ATERIAL EXPEDIT	ER	GM	
1 0	il Hygi other /ent, t	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle,	Maiden Surname)	
<u>lar</u>	should be nd Mental marked c	To B	PETER P. WASKIEWICZ		MARY	TANSK	Α	
Maryland	2 sho and I s ma		19a. Informant's Name/Relationship (Type. Print)	1	ng Address (Street and Number or Rur			
ტ 	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		WANDA WASKIEWICZ / WIF 20a. Method of Disposition			GEWOOD Date	, MD 2104	
Baltimore,	0 0 - L		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	METRO (CREMATORY 6/1	9/07	BALTIMORE,	MD
Ball	permit. Pag Department Important: i any Injury o once.		21. Signature of Eurotti Service Licensee		2. Name and Address of Facility CV. 1211 CHESACO AV.	ENUE B	ALTO., MD	21237
П			23a. Part1: Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li			or respiratory ar	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	nterdigic	Rectal Bleeding		(ne day
	Examiner			a consequents of):				
		Jer	Sequentially list conditions, if any, learning to him reducte cause. Enter Underlying Cause (Disease or injury	a consequence of):				
	cuted nd transit	Examiner	that initiated events					
20	ficate be executed physician and s the burial-transit	E	Due to (or as	a consequence of):				
68760	ficate t physic s the b	edical	d					
P.O. Box 6	eath certi attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	ery Day Year
σ.	that the plant of		Part II. Other significant conditions contributing to death b	ut not resulting in the	underlying cause given in Part i.	23e. Did t	obacco use contribute to	he cause of death?
rds	quires en sign	ed by	Congestive Heartfailure			1 🗆 '	Yes 20 No 3 Pro	bably 4 ☐Unknown
Reco	sician: The law requires that the de certificate has been signed by the : rector, page 2 should be detached	Completed				24a. Was autop perfo	psy prior to co prmed? death?	opsy findings available ompletion of cause of
ţ	ian: ortifica ctor, p	Be C	25. Was case referred to medical examiner?		26. Place of Deat			
× ×	Physic this ce al dire	To	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpati				dence 6 Other (Spec	fy)
п	ing P	ion:	27. Manner of Death Natural 5 Pending (Month, Da		of 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe	how injury occurred	
Division or Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of in building, e	iury - At home, farm, s tc. <i>(Specify)</i>		28f. Location (: City or To	Street and Number or Rui wn, State)	al Route Number,
_	To the Hospital within 24 hours a To the Funeral I completely filled	Medical Ce	29a. Certifier (Check only one) Certifying Physician: To the best 2 Medical Examiner: On the basis and manner st	of examination and/or i	ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the rred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	ro the vithin: To the comple	Mec	29b. Signature and title of certifier		29c. License number		29d. Date signed (Month	
	C > F 0		I perha the m		000048050		6/18/07	•
	6		30. Name and address of person who completed cause of a Prashant Shukla M 15	death (Item 23a) (Type	reet #400 Abord	een mi	21001	
Ì	Sta Regist		30. Name and address of person who completed cause of or Prashant Shutla who 15 31. Date filed (Month, Day, Year) 32. legist JUN 1 9 2007	rar's Signature	and the same of th			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

10	12	100	400	9	3	-1-3		
1			7			- 7	6	
6	100		á	1	_	- 6	1.0	

Tyree Lamar William	ns State of Maryland / Department of Health and Mental Hygiene 2. U U 1-For State Certificate of Death Reg. No.	1 1310
	Registrar 2. Date of Death 3. Decedent's Name (First, Middle, Last)	Time of Death
N I Examiner	Tire Lamar Williams June 13, 2007	1003 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	
	University of Maryland Medical Center Baltimore 5 Social Security Number 6 Sex 7, Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MW/DD/YYYY) 9. Birthpla	ace (State or
Funeral Director	Months Days Hours Min. O. 2 a.s. 1.00 J Foreign	400
Director	18-06-18-30 Fm 2-1 AX	7776
more in the most date tender	1 10a, State 10b, County 10c, City, Town or Location	d. Inside City Limits
show :	1 1110) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Yes 2 No
the Maryland a or 28a-f sh iified at once Director	10e. Street and Number	?
3a or office		Indian Black
r death with the Maryland or items 23a or 28a-f show any must be notified at once. Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American White, etc.	I Indian, Diack,
or it, or it	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: Specify:	ick
136 hin 72 hours after than "natural", edical Examiner	or Dates: 16 Decedent's Usual Occupation (Give kind of work done) 16b. Kind of Business/Indu	ustry
n "na al Ex	Elementary/Secondary (0-12) College (1-4 or 5+)	
5-0036 ed within 72 hour tygiene. other than "natt	12 Fother's Name (First, Middle, Last) 13 Fother's Name (First, Middle, Maiden Surname)	
215-0036 be filed within 7 mial Hygiene riked other than ent, the Medica Be Comple	17. Father's Name (First, Middle, Last) Eric Williams Adrienne Jordan	_
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other tranmatic event, the Medical Examiner must be notified at Lonce. To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print)	
MD shot of the and of	Adrienne D. Jordan Mother 14905 St. Gemma Rd., Baltimore, M	
Baltimore, MC pernit. Pages I and 2 si Department of Health an Important: If item 27 injury or other trauma	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City of 10c. Control of City of 10c. Control of City of 10c. Control of City of 10c. Control of City of 10c. Control of City of 10c. Control of City of 10c. Control of City of 10c. Control of City of 10c. Control of City of 10c. City of	
imor Pages nent of ant: 11 or othe	The las Mamaria I blad 2007 Daitiful	
Baltimore, permit. Pages I ar Department of Hee Important: If ite	21, Signature of Funeral Service Ligensee 22. Wine and Address of Facility Frence funeral Service	Ces 1229
	Vaushow C. Steene 5151 Batto. Nat'l Y: (e., Batto., MD of 23a. Part I. Boler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	Approximate Interval
/ hysician Medical	failure. List only one cause on each line.	Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	
	Sequentially list conditions, b.	
iner		
ted last	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
scuted and transi		
(ecords, P.O. Box 68760, The law requires that the death certificate be executed are has been signed by the attending physician and bage 2 should be detached for use as the burial - transit	UNPENDED AMENDED 23d. Date of delivery	
760 ficate g phy: s the b		y Year
Box 6876 s death certificate the attending phy ed for use as the hvs.ic.ian/M	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	
by the at iched for	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the	e cause of death?
P.O.		
duires sen signal be		opsy findings available impletion of cause of
Records, The law requires froate has been sig, page 2 should be	autopsy performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	
Rec ficate	26.Place of Death (Check only one)	
ital sicians is certi irector	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other:	
Division of Vital Records, ral or attending Physician: The law requirms after death. The Director: After this certificate has been sited in by the funeral director, page 2 should the fine at the Commister.	27 Magner of Death 28a Date of Injury 28b. Time of Injury 22c. Injury at Work? 28d. Describe how injury occurred	
on cending auth.	Natural 5 Pending Investigation O032 hrs 1 Yes 2 No O32 hrs 1 Yes 2 No	
VISE or Att fler de Directo in by	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rur or Town, State)	
Division of Vital Hospital or Attending Physician: Part hours affect death tely filled in by the funeral director,	Suicide determined (Specify) Alley 3200 Block Phelps Lane, Baltimore,	
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the consistence of the constituent of the constituen	29a. Certifier (Check only one) 29a. Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the	cause(s)
To the b within 2 To the 1 complete	Certifying Physician: To the best of my knowledge, death occurred at the line, date and place, and due to the one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and place, and due to the one) 29b. Signapare and title of certifier 29c. License number 29d. Date signed (Montal Examiner)	
	290. Signaple and the si senting. O.C.M.E. June 15, 2007	
09	30. Name and address of person who completed cause of death (Item 23a)	
5	Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Sta	TITAL S VI / IND PROBLEM AND A PARTY	
Registra	ar JUN 1 9 2001 Black to report	

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend #17, per INF, 6808, 6/20/07 IT Certificate of Device Programment of Programment Of P 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** tebben and lyn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Anne Arundel Glen Burnie If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country)
 PA 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 □ M 2 🕅 F 82 Feb. 10. 1925 204-18-1687 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 277No Directo Odenton MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21113 U.S.A. 525 Higgins Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ Vol If Yes, Give 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2√√No Specify. Specify 2 3 XXVidowed 4 □ Divorced Year or Dates White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Garment Industry 11 Seamstress permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygic Important; If item 27 is marked other any injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles William Tanner Be Pearl Matthews Webber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Odenton, Maryland 21113 Mr. John Webber / son 525 Higgins, 20b. Place of Disposition (Name of cemetery, crematory or other place) em 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 【 Removal from State 06/20/2007 St. Paul's Lutheran Middleport, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Singleton Funeral Home, P.A. 22. Name and Address of Facility Glen Burnie, MD Second Ave, SW 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) idden Doct Physician /Medical Due to (or as a consequence of): Examiner diomy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury test initiated executions) Examiner revolve The law requires that the death certificate be executing that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the l IF FEMALE nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for 1 Month Day Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 25 detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has page 2 certificate 1 Yes Hospital or Attending Physician; funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: **≥**100 1 🔲 Inpatient 2 MR/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tyes Certification: To this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury (Month, Day Year) 1 Natural 5 ☐ Pending investigation To the Hospin...
within 24 hours after death.
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 8

State Registrar DHMH 17 Rev 1/2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

31. Date filed (Month, Day, Year)

Michael C. Bond 301 Hospital Drive Glen Burnie MD 21061 3 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 11 per fh 9868 6-19-0/vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** WHYE 6:00 AM MARTEL JUNE 2007 13 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Hospital 1+1 Johns HOPKINS 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 220-52-3413 1 MM 2 □ F 59 05-4-1948 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 No MD timore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 N Yes 2 No 12-12-1961 If Yes, Give Year or Dates: 12-5-1969 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Black Specify. Specify: Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO_NOT use retired) City Water Work Elementary/Secondary (0-12) College (1-4or 5+) Filtration Operator 12×5 ayr Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) non ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Balto Dinah Whye Wife MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Garrison Forest Cem: 19-2007 Owings Mills MD 4 □ Donation 5 □ Other (Specify) 1814 upshur St N.W. 21. Signature of Funeral Service Licensee elt Funeral Chapel Washington, DC20011 Hacker W 23a. Pant1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) STROKE **Physician** HEMORRHAGIC 12 days /Medical Due to (or es e consequence of): Examiner SHOCK 10 days SEPTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed 20 Years HIV for use as the burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) a I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by VENTRICULAR THROMBUS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No HEPATITIS B 24a. Was an autopsy 1☐ Yes 2 No To the Hospital or Attending Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier within 24 ho

To the Fun

completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D JUNE, 13, 2007 RES - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

ABOU- KHAMIS

32 Registrar's Signeture

31. Date filed (Month, Day, Year)
JUN 1 9 2007

GOO N. WOLFE STREET

21287

MD

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Theresa G. Waudby June 3:40 A. M 2007 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Health & Rehab. Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 47 Maryland 213 78 6748 Director Sept. 1959 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10h County 10d. Inside City Limits 1 ☐ Yes 2 ▼ No Director Linthicum Maryland Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21090 305 Jerlyn Avenue by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2K Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No If Yes, Give Year or Dates: Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dewey Welborn Polly Weatherman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert Waudby / Husband 305 Jerlyn Avenue Linthicum, Marvland 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD. State Veteran Cem.6/14/2007 Crownsville, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the disease, or shock, or heart failure List Immediate Cause (Final disease or condition resulting in death) Breast Cance **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Division or Vital Records, P.O. Box 68760, attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ▼No 24a, Was an autopsy performed? Yes 2 To the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ဥ 1 Inpatient After this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident neral Director: , filled in by the f 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JUNE 11, 2007 rwsteran Eduin Raymor Blvd Suite A Pasadena MD 2122 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8094 Agaielin Nnaemeka 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene.	important: If item 27 is marked other than "natural", or items 23a or 28a-f show	any Injury or other traumatic event, the Medical Examiner must be notified at	
Ph	y:	sic	ia ic	11
E	ca	mi	ine	9
ng Physician: The law requires that the death certificate be executed		fer this certificate has been signed by the attending physician and	funeral director, page 2 should be detached for use as the burial-transit	

ior	1	1. Decedent's Name (First, Middle, Last)					2. Date of De	ath Day	Year	3. Time of Death	
ian ical		SYLVIA D			WEISE		JUNE		2007	6:10 A	
ner	4	4a. Facility Name (If not institution, give street and	d number)		4b. City, Town, or Location of Death				ounty of Death		
	5	CASEY HOUSE 5. Social Security Number 6. Sex	7. Age (In vr	rs. last birthday		VILLE If Under 24 Hr	s. 8. Date of Bir	th	MONTGOM 9. Birthr	IERY place (State or For	
		105-24-5543 ^{1□ M 2} √X		Vrc	Months Days	Hours Mir		y, Year)	Coui	ntry) NY	
	-	Usual Residence of Decedent		City, Town or L	ocation		100/ 23/			I0d. Inside City Lir	
ō	Ι΄	GA 10b. County		ATLANTA						1 ☐ Yes 2 ☐	
Director	1	10e. Street and Number		ATEANT	10f. Zip Code			10g. Citize	n of What Cour	ntry?	
'al Di		3200 LENOX ROAD N. E	. APT B4	06				Ü	U.S.A.		
Funer	1	11. Marital Status 12. Was	Decedent Ever in d Forces?		. Was Decedent of If Yes, specify Cul	Hispanic Origin? ((Specify Yes or No erto Rican, etc.)		. Race - Americ Black, White,		
b		1 Never Married 2 Married 1 Nf Yes	es 2 ሺ No s, Give or Dates:		1 □ Yes 2 No		atto (ilidaili, otd.)	S	pecify:	WHITE	
Completed		15. Decedent's Education (Specify only highest grade comple	ted)) (Giv	edent's Usual Occu e kind of work done	during most of w	orking	16b. Kind	of Business/In	•	
E I		Elementary/Secondary (0-12) Colle	ge (1-4or 5+)		DO NOT use retire LESPERSON	•		LADI	Foots ES FOOT		
ပိ	1	17. Father's Name (First, Middle, Last)			LLOI LINOON	T	ame (First, Middle			WAILE	
To Be		SAMUEL	K	CUNER		FRITZI			TIE	FER	
		19a, Informant's Name/Relationship (Type. Print))	19b. Mai	ling Address (Stree	t and Number or F	Rural Route Numb	er, City or T	own, State, Zip	Code)	
	1	DAVID LESSER / SON	1		VENDOME	DRIVE -					
	2	20a. Method of Disposition 1 XI Burial 2 □ Cremation 3 XI Removal f	rom State	cemetery, ch	osition (Name of ematory or other pla	i i	Date		tion - City or To		
	-	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Sorvice Licensee	CE	DAR PAI	RK 22. Name and Addr				ON, NJ.		
	'	21. Signature of Full Hall Service Elegange	-	. '			SOL LEVI IN ROAD -				
	T	23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause	hat caused the de	eath. Do not er						Approximate Interval Between	
	1	Immedial Cause (Final disease condition		NTRACE	REBRAL HE	MORRHAGE				Onset and Deat	
		resulting in death)	e to (or as a cons								
	1	Sequentially list conditions, if any, leading to immediate	e to (or as a cons		GKINS LYM	PHOMA			4		
Examine	- (Cause, Chieada or injury that initiated events c									
	i		e to (or as a cons	equence of):						· · · · ·	
dical		d					·				
Med	-	IF FEMALE:									
Physician/Me		23b. Was decedent pregnant in the past 12 months?	s, outcome pf preg live birth 2□Fe Pregnant at time o Jnknown	etal death 3	□Ectopic pregnan □ Other <i>(specify)</i>	су		23	d. Date of deliv Month	ery Day Year	
	F	Part II. Other significant conditions contributing	to death but not re	esulting in the	underlying cause g	ven in Part I.	23e. Did	obacco use	contribute to t	he cause of death	
ed by							1 🗆	Yes 2□	No 3 ☐ Pro	bably 4 X ⊐Unkn	
Completed	Ĺ						24a. Was		24b. Were auto	opsy findings avail	
, mo								ormed?	death?	2 No	
Be (2	25. Was case referred to medical examiner?					eath (Check only				
2	1	1 ☐ Yes 2 🛣 No Hospital:	1 Inpatient 2	ER/Outpatie	SIIL SELDON		Home 5 ☐ Res			_{fy)} HOSPICE	
tion	1	1 X Natural 5 ☐ Pending	Month, Day Year)		W	ary aτ ork?]Yes 2 □ No	28d. Describe	now injury (occured		
fica		3 Suicide 6 Could not be determined 28e.	Place of injury - At	home, farm, s	treet, factory, office		28f. Location (Street and	Number or Run	al Route Number,	
Certification:		4 Homicide determined	ouilding, etc. (Spe	ecny)			City or To	wri, State)			
gdic	2	29b. Signatu (e/and title of certifier Anonore Uno	han s	E mis		se number 0 6 4 6	15	29d. Date	signed (Month, 17 ,	Day, Year) 2007	
Medical											
Medica	3	30. Name and address of person who completed Genevieve Anne Wroblewski,									

DHMH 17 Rev 1/2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Danie	el Patrici	k Yo		1- For State	State of	Marylaı		artment of		nd Mental H			AR TRIP
	Phys		in/	Registrar 1. Decedent's Name (First, M							2. Date of Deal	eg. No. th Day Year	3. Time of Death
Medi	ical Exa	amii	ner	Daniel Pat	trick	Young			n City Town o	r Location of Deat	June 14, 2	4c. County of	1620 hrs
				211 Victor Parkway	_		iber)		Annapolis	Location of Deal	ui	Anne Arur	
	Funer			5. Social Security Number	6. Sex	7	7. Age (In yrs. la	• •	If Under 1 Yea		s. 8. Date of Bir	th(MM/DD/YYYY)	9. Birthplace (State or
J. S.	Direct	or		219-29-7120		2F		19 _{Yrs.}	Months Day	ys Hours Mi	n. 10/19	/198/	Foreign Maryland
	any			Usual Residence of Deceder 10a. State 10b. Cou	nty		10c. City,	Town or Location	on .				10d. Inside City Limits
9	put show :	nce.	5	Maryland	N/A			Ва	ltimore	5			1 X Yes 2 No
10120	Maryla r 28a-f	ed at o	Director	10e. Street and Number	Avanua				10f. Zip Code	21206	1	0g. Citizen of What	
\subseteq	vith the	notifi		4408 Raspe			dent Ever in U.	S 113 Was		21206 ispanic Origin? (§	Specify Yes or No	U.S.	American Indian, Black,
	death v r item	nust b	Funeral	1 X Never Married 2	Married 1	Armed For				n, Mexican, Puert		White,	etc.
	s after ral", o	liner n	by F	3 Widowed 4	Divorced of	Yes, Give Year Dates:			Yes 2 X No			Specify:	White
	2 hour	Exan	eted	15. Decedent's Education (Elementary/Secondary (0-		College (1-		during mo	st of working life	ation (Give kind of e. DO NOT use re		16b. Kind of Busin	·
	036 vithin 7 ene. er than	Medica	ompleted	12			·	Wai ⁻	ter			Food Ir	ndustry
į	c filed very fall Hygi	nt, the	Be Co	17. Father's Name (First, Mic Patrick J		g						Maiden Surname) e Waggone	er
	hould bad Men	itic eve		19a. Informant's Name/Relati								nber, City or Town,	
	and 2 s eaith ar	trauma		Patrick J. Yo	oung -	ratne		44U			Balt1mo	re, MD 21	L Z U b Sity or Town, State
	Baltimore, MID 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho	njury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Crema 4 Donation 5 Othe	_	Removal fro	m State Lal	crematory or oth Keview I	erplace) Memorial	Park 0	6/19/200		/ille, MD
:	Salti ermit. Separtm mports	njury o		21. Sign e of Funeral Ser			1		ame and Addres	s of Facility	Inc 53	05 Harfor	d Road MD 21214
	Physicia		-1	23a. Part I. Enter the discusse	e, or complice	tions that ca	used the death						
	/Medic Examin	al		failure. List only one ca Immediate Cause (Final dise	use on each	line.	1000) intoxica			Between Onset and Death
	<u> </u>	Ü		or condition resulting in deat			consequence o						
-	1		niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Car	use	e to (or as a	consequence o	f):					
	uted	ansit	Examine	(Disease or injury that initiate events resulting in death) La	= =	e to (or as a	consequence o	f):					
	UIVISION Of VITAL RECORDS, P.O. BOX 68/60, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	burial - transit	edical	Xunpended	_ A	MENDED #23a.2	7.28a-f.	perME, g8	369. 7/10 _/	/07 TT			
ì	8/6(bificate ng phys	hed for use as the b	5	IF FEMALE: 23b. Was decedent pregnant		23c. If yes, or	utcome or preg	Haricy	al death 3	Ectopic pregr	nancy	23d. Date of de Month	elivery Day Year
•	OX 6 ath cer	or use	sicia	past 12 months? 1 Yes 2 No 9	Unknown		nt at time of de	ath =	er (Specify)				,
1	the de by the	iched f	Phy	Part II. Other significant co		g Unknov		esulting in the u	derlying cause	given in Part I.	23e. Did to	obacco use contribu	ute to the cause of death?
ì	res that signed	d director, page 2 should be detach	d by								1 Yes	2 No 3	Probably 4 VInknown
•	ords * requi	plnods	Completed								24a. Was autop		ere autopsy findings available or to completion of cause of
	Kecc The lar	page 2	E O								1 Ves		ath? ✔ Yes 2 No
	ician: ician: s certifi	director, page	Be	25. Was case referred to me examiner?	dical Hos	pital:		ED/O Louison		of Death (Check			
	of V g Phys fter this	neral di	٦.	1 Yes 2 No 27. Manner of Death		28a. Date o	patient 2 f Injury	ER/Outpatient 28b. Time of In		ury at Work?		Residence 6 🗸	
	tendin eath. tor: A	the fur	cation		Pending nvestigation		Day, Year) /14/2007	Fnd 4:07	. pm	Yes 2 X No	unk		
	IVIS lor At after d Direct	filled in by the funeral	ertific	3 Suicide 6 X	Could not be			ome, farm, stree	, factory, office	building, etc.	or Town, S	itate)	or Rural Route Number, City
•	Lospita f hours uneral	ly fille	91	4 Homicide 29a. Certifier		(Specify)		n dwellin		tate and place, an		or Pkwy. Ap	t G Annapolis, MD
	o the I ithin 2, o the F	completely	ledical		Examiner: Or		examination a					and place, and due	
(3)	F » F	ŭ	¥	29b. Signature and title of ce	rtifier	a marinor ba	itou.		29c. Licens			29d. Date signed	(Month, Day, Year)
	1			my hu		_			O.C.	M.E.		June 15, 200)7
l)			 Name and address of per Ling Li, MD Assi 	son who com stant Med		•	^{23a)} Penn Stree	, Baltimore,	MD 21201			
(*	m		ate	31. Date filed (Month, Day Ye	9 2007	32 teg	istrar's Signat	* Age	(i)				
	_/ Reg	gist	rar	JUN 1	V 4001		A	1	The st				

DHMH 17 Rev 1/2001

State

Registrar

Peterson

9

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1 - For State Registrar	State of Mar	yland / Dep		Health and M	fental Hygie	-	19773
			1. Decedent's Name (First, Middle, L	496				2. Date of Death	B- V	3. Time of Death
	Physic /Medi		Mary	Lelle	~			Month	Day O Year	C 20(4M)
	Examir		4a. Facility Name (If not institution, 9	ive street and number)		4b. City, Town,	or Location of Death		4c. County of Death	1
			Oak Crest			Park	ville		Baltim	nore
	Funeral				In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,)		nplace (State or Foreign untry)
	Director		213-16-3439	1□M 2√2F	86 Yrs.	WOTHIS Days	, riodis iviii.	September		ryland
-	pu k		Usual Residence of Decedent 10a. State 10b. County		Oc. City, Town or Lo					
2	ehov det	-								10d. Inside City Limits
ran	8a-f	octo		ltimore	Pi	arkville				1 ☐ Yes 2√No
L.	hours after death with the Maryland lural, or Itema 23a or 28a-f ehow al Ezaminar roual be notified at	Funeral Directo	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	untry?
	ath v	rai	8800 Walther Blvo				21234		USA	
_	er de	une	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of If Yes, specify Cut	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
98	, or	by F	1 Never Married 2 Married 3 XWidowed 4 Divorced	1 ☐ Yes 2 ☑No II Yes, Give Year or Dates:		1□Yes 2☑No	Specify:		Specify:	1.15-2-4
			15. Decedent's		163 Doop	dent's Usual Occu	ration	1 46	1	White
215		Completed	(Specify only highest g	rade completed)	(Give	kind of work done DO NOT use retire	a during most of work 9d)	ing	6b. Kind of Business/I	ndustry
	with than	E	Elementary/Secondary (0-12)	College (1-4or 5+)			epresentat		C & P Tele	
B	e filed value of Hygie of I other fivent, it	Ö	17. Father's Name (First, Middle, Las	t)		STATE 1/6		First, Middle, Ma		hunus
an	d be ental ked c	To Be	Louis R. McKe	rnen			Mari	e Debes		
Maryland	2 should be and Menta Is marked aumatic ev	-	19a. Informant's Name/Relationship		19b. Mailir	na Address (Stree			City or Town, State, Z	in Code)
Z €	nit. Pages 1 and 2 should be filed within timent of Health and Mental Hygiene. ortant: if item 27 is marked other than Injury or other traumatic event, the m.	1	Mr. James C. Zeller		Texas		er Place Ast			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
A 5	is 1 and of Health item 27 other tr		20a. Method of Disposition		20b. Place of Dispo				Oc. Location - City or 1	Town, State
)£	permit. Pages Department of Important: If it any Injury or o		1 ☐ Burial 2 ☐ remation 3 4 ☐ Donation 2 ☐ Other (Spec		Hilltop Ser		1	מרחם	T M	
Baltim	artme ortar Injur		21. Signatura of Funeral Service Lice			Name and Address	6.15.2	JU/	Tawan Mary)	
7 8	Dep Imp		Machael V	Buck XI				T AFF		21214
	100 m		23a. Part . En er the diseas . or conshock, or heart failure. List only	nplications that caused th	e death. Do not ent	er the mode of dvi	Ing. such as cardiac	or respiratory arres	York Road	Approximate
			shock, or heart failure. Mst ont						"	Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	a	d-Sta	Je CH				
16	Examiner			Due to (or as a c	consequence of):					
20%	186	e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	onsequence on:					
14	uted ansit	盲	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
1	exec n and ial-tra	Examiner	resulting in death) Last	CDue to (or as a c	onsequence of):					
760	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	cai		d						
	ificat g phy as th			J						
Вох	ndin ndin	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of deliv	verv
m	death a atte	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 [4□Pregnant at tim		Ectopic pregnanc Other (specify) _	су		Month	Day Year
P.O.	the oy the ache	hys	9 ☐ Unknown	9□ Unknown						
<u>.</u>	that ned b deta	by PI	Part II. Other significant conditions	contributing to death but r	not resulting in the u	nderlying cause gi	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
g .	arie n sig uld be	d b	d	ementa				1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Unknown
8	w rec bee	Completed						24a. Was an	24h Wasa aut	anau findana available
Be	aler has ge 2	ш						autopsy performe	prior to or death?	opsy findings available ompletion of cause of
<u>'</u>	ncian: The lav certificate has rector, page 2		05.14					1 Yes 2.	No 1 ☐ Yes	2 No
=======================================	certi	Be	25. Was case referred to medical examiner?	Hospital:		Ott	hor	(Check only one)		
Division of Vital Records,	Jing Phys	<u>7</u>	1 Yes 2 No 27. Manner of Death	1 Inpatient	2 ER/Outpatien	T 3L DOA	4 Nursing Ho		ce 6 □Other (Spec	ify)
0	ding h. After fune	Certification:	1. Natural 5 ☐ Pending	(Month, Day Y	ear) Injury	Wo	rk?]Yes 2□No	28d. Describe how	injury occurred	
2	deat deat ctor: y the	lica	3 ☐ Suicide 6 ☐ Could not	OB Olean of Inium	- At home larm etr			281 Location /Stree	et and Number or Rui	m I Pouto Alumbos
<u>S</u>	after Dire	erti	4 Homicide determined	building, etc. (Specify)	oot, lactory, critico		City or Town,	State)	ar noble Norriber,
_	To the respitator Atlanding Physician: The law requires that the death certifica within 24 hours after death. within 24 hours after death. completely filled bliector: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as it.		29a. Certifier Lertifying P	hysician: To the best of n	ny knowledne death	occurred at the ti	me date and place	and due to the com-	se(s) and manner :-	claied
	24 h	edical	(Check only 2 Medical Exa	and manner stated	amination and/or inv	estigation, in my	opinion, death occurr	ed at the time, date	and place, and due	to the cause(s)
	vithin o th	Me	29b. Signature and title of certifier	- A (7 1	29c. Licens	se number	29d	. Date signed (Month	Day, Year)
•	> - 0		14 AS	W	M)	1/ 2	4247		ilitas	
	1D		30. Name and address of person who	completed cause of deat	Nitam 23a) (Tun-	Print	1-11		-1117	
	1		B CE LUM	nhi w	1 23a) (Type,		& Blun	Dellar	the ind	2(234
*	Sta	te	31. Date filed (Month, Day, Year)	32/Registrar's		M.	7.03		the holy	
	Registr	-	JUN 1 9 1	1007 Lines	D. AD	BARAS				

DHMH 17 Rev 1/2001

Physician Examiner he law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

Sequentially list conditions, if any leading to infinite date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical examiner? Be ٩ 27. Manner of Death Certification: 5 ☐ Pending investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number

ate has been signed page 2 should be de ector. within 24 hours after death.

To the Funeral Director, After this of completely filled in by the funeral director.

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

rai", or items 2 Examiner mu

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Interest if item 27 is marked other than "natural", or ite nry or other traumatic event, the Medical Examine.

Department of Important: If its any Injury or of once.

/Medical

burial-trar

the as use

for

detached

Baltimore, Maryland 21215-0036

Directo

Funeral

þ

Completed

Be

ဂ္

with the Maryland

death v

5 State

MEDICAL LOCTOR

064931

29d. Date signed (Month, Day, Year) JUNE, 18, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVIS COSCREVE, THE JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BALTIMORE, MS 21287

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

manes beagle		- For State	or Maryland / D	-	ate of Death	u Mentai i i	ygierie Reg.	No. 201	17 1977
Physicia	n/	Registrar 1. Decedent's Name (First, Middle,Las					2. Date of Death		3. Time of Death
Medical Examir		Charles Richard 4a. Facility Name (if not institution, given			4h City Town or	Location of Death	Month E June 10, 20	4c. County of Dea	1347 hrs
		Laurel Regional Hospital	e street and number)		Laurel	LOGGION OF DOLL		Prince Georg	
Funeral Director		5. Social Security Number 6. S 219-46-3284	ex 7. Age (In 57	yrs. last bii	thday) If Under 1 Yes Months Day		-	Fore	irthplace (State or ign ountry) MD
any	-	Usual Residence of Decedent 10a. State 10b. County	10c	City, Towr	or Location				10d. Inside City Limits
	٦	MD Montgo	mery	Silv	er Spring				1 Yes 2XX No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 1901 Henderson A	ve		10f. Zip Code	20902	10g	. Citizen of What Co USA	untry?
r death with or items 2: must be no	Funeral	11. Marital Status 1 Never Married 2XX Married	1AX Yes 2		13. Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto		White, etc.	erican Indian, Black, hite
rs after ural", miner	<u>آھ</u>	3 Widowed 4 Divorcer 15. Decedent's Education (Specify of	or Dates:	ed) 16a	1 Yes 2XX No.		work done 1	Specify: W	
215-0036 be filed within 72 hours al ntal Hygiene. ked other than "natural ent, the Medical Examin	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		during most of working life Park Maintai	e. DO NOT use reti		Prince County	George's Parks
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	8	17. Father's Name (First, Middle, Last Clarence Beagle				Ida M	e (First, Middle, Ma arguerit	e Butts	
y, MD 21 and 2 should lealth and Me tem 27 is mai	٥	19a. Informant's Name/Relationship (Cheryl Beagle/wi			9b. Mailing Address (Stre 1901 Henders				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Specific		crema	of Disposition (Name of co atory or other place) peake Cremat	· 1	Date /19/2007	20c.Location-City Beltsvi	
Baltil permit. Departm Importa	Ì	21. Signature of Funeral Service Lice	nsee	0382	22. Name and Addres		•		tion Service
Physician /Medical		23a. Part I. Enter the disease, or com failure. List only one cause on e	plications that caused the ach line.				or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
Examiner	1	Immediate Cause (Final disease or condition resulting in death)	Hypertensive Ather		ic Cardiovascular Di	sease			Death
	<u>اة</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	nce of):					
_	Examiner	cause. Enter Underlying Cause	Due to (or as a conseque						
760, cate be executed physician and the burial - transit	E E								
30, te be ex ysician burial	Medical	UNPENDED IF FEMALE:	AMENDED 23c. If yes, outcome o	fpregnanc				23d. Date of deliv	erv
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/N	IP FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	1 Live birth 4 Pregnant at time		2 Fetal death 3 5 Other (Specify)	Ectopic pregn	ancy	Month	Day Year
). Bc the deal	Phys	Part II. Other significant conditions	9 Ulikilowii	t not resulti	ing in the underlying cause	given in Part I.	23e. Did tob	acco use contribute	to the cause of death?
, P.C res that signed be deta	d by						1 Yes	2 No 3 P	robably 4 Unknown
ords w requi	Completed					_	24a. Was ar autops	y prior t	autopsy findings available o completion of cause of
Reco	Com						perform 1 Yes 2		
ician:	B	25. Was case referred to medical examiner?	Hospital:	2 - 4 - 50/		Other: Nursi		tesidence 6 Ot	nor:
of Vi	은	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day,Year)		Outpatient 3 DOA DOA DOA 28c. Inj	ury at Work?		ow injury occurred	iei.
ion (tending eath.	gion	1 Natural 5 Pending 2 Accident Investiga			1	Yes 2 No			
Divisitian or Attura or At	Certification:	3 Suicide 6 Could no determin	t be 28e. Place of Injury	- At home,	farm, street, factory, office	building, etc.	28f. Location (St or Town, Sta		Rural Route Number, City
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifying Physi	cian: To the best of my kner:Of the basis of examina	owledge, dation and/o	eath occurred at the time, rinvestigation, in my opinion	date and place, an	d due to the cause at the time, date a	(s) and manner as s nd place, and due to	tated. the cause(s)
	Me	29b. Signature and title of certifier				nse number		29d. Date signed (/	Month, Day, Year)
1041						.M.E.		June 12, 2007	
OCME		• • • • • • • • • • • • • • • • • • • •	eputy Chief Medical			et, Baltimore, I	MD 21201		
St Regist	ate rar	31. Date filed (Month, Day Year) JUN 2 0	32. Resistrar's S	Signature	Sporte				
	_								

DHMH 17 Rev 1/2001

7

State Registrar JOHN

31. Date filed (Month, Day, Year)

mela

Gaithily md. 20879

and address of person who completed cause of death (Item 23a) (Type, Print)

911

32. Restrar's Signature

Multel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1 - For State Registra Certificate of Death 3. Time of Death 6:46 AM 2. Date of Death 1. Decedent's Name (First, Middle, Last)
Earl Hugh Brunson June 14, Day 007 Year Physician /Medical 4c. County of Death Montgomery 4b. City, Town, or Location of Death
Takoma Park *WESN'INGTON 'AUVENTISE and number) tal Examiner If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign
 NCountry) 7. Age (Argrs. last birthday) 8. Date of Birth 0/80/11 59/1960 5 Social Security Number 2 2 9 - 04 - 4 1 3 1 **Funeral** Months 1/M 2 F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Plygiene.
ant: if Item 27 is marked other than "natural; or Items 23a or 28s-f show ury or other traumatic event, if a Marylan Esaminat must be notified at 10d. Inside City Limits 10h County 10c. City, Town or Location NC Durham Durham 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 1116 Juniper St. 10f. Zip Code 27701-Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Specify: Black 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 ð 3 ☐ Widowed 4 ☐ Divorced Be Completed Hospital ness/Industry 16a. Decedent's Usual Occupation
(Give kind of work done during most of working tie. DO NOT use retired)

Medical Tech 15. Decedent's Education (Specify only highest grade completed) College (1-4orf5+) Elementary/Secondary (0-12) 18 Mother's Name *(First, Middle, Maiden Suma*me*)* Earnestine Shine 17. Eather's Name (First Middle, Last) Earl Hugh Brunson 19b Mailing Address (Street and Number or Rural Route Number - Tity of Town, State, Zip Code) 1 Statement's Name British Sign / Mother 20b. Place of Disposition (Name of Dam 19 20c. Location - City or Town, State 20a. Method of Disposition Beltsville, Maryland Chesapeake Crematory 2007 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. 4 □ Donation 5 □ Other (Specify) Rappe Function Services 21. Signature of Funeral Service 933 Gist Ave. Silver Spring, Maryland 20910-Tohuman complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner ARDIAC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner DICUBITUS ULCER attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, END STAGE RENAL DISEASE Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 No 1 Yes certificate or Attending Physicien: : After this certification of tuneral director. 25. Was case referred to medical 26. Place of Death | Check only one) Be examiner' Cther: 4 ☐ Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 27. Manner of Death 28c. Injury at Work? 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

To the Hospitel or Attending within 24 hours after death.

To the Funerel Director: After completely filled in by the funs.

Chandrosekhar Korapati MD P.O. Box 835 Greenbelt MD 20768 31. Date filed (Month, Day, Year) State JUN 2 0 2007 Registrar

29b. Signature and title of certifier

(Check only one)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

MD 52855

29d. Date signed (Month, Day, Year)

06-14-2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Physician /Medical Examiner	1. Decedent's Nam <i>e (First, Middle, La</i> Mary Beall	st)						
/Medical Examiner uneral	Mary Beall					2. Date of Dea Month		3. Time of Death
uneral						May 25	, 2007	2:20 AM
	4a. Facility Name (If not institution, give			4b. City, Town, or		th	4c. County o	
	Annapolis Nurs 5. Social Security Number 6.5	9	n yrs. last birthday	Annar		8. Date of Birt	h	Arundel
rector		1 M 2 N F	82 Yrs.	Months Days	Hours Min		1925 I	9. Birthplace (State or Foreig Country) Maryland
A =	10a. State 10b. County	10	Oc. City, Town or L	ocation	***************************************			10d. Inside City Limits
to to	MD Anne A	rundel	Annap	olis				1 ☐ Yes 2√ No
irec	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?
ai D	900 Van Buren St	reet		21	401		US	SA
or iteme 23e or 28e-f e niner must be notified Funerai Director	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (s n, Mexican, Pue	Specify Yes or No- to Rican, etc.)	14. Race Black	- American Indian, , White, etc.
D S	1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced	1 □ Yes 2 📉 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:			white
t, the Medical B	15. Decedent's E (Specify only highest gr	ducation	16a. Dece	dent's Usual Occup	ation	ndkina	16b. Kind of Bus	iness/Industry
Men.	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	,,,,,,,,		
Cor		unk		housewif				wn home
To Be	17. Father's Name (First, Middle, Last)		unk	18. Mother's Na	me (First, Middle,	Maiden Sumame) un
eman le	19a. Informant's Name/Relationship			ing Address (Street				state, Zip Code)
hert	Mary Walbrum/nied		5727 20b. Place of Disp	64th Plac	ce River	dale, MD		City or Town, State
Important: If its eny injury or of once.	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☒ Other (Speci	Removal from State	cemetery, cre	matory or other plac	a) 	Date	20C. LOCATION - C	ony or rown, state
eny Inj	21. Signature of Euneral Service Lice ROTIALD S.	Wade, Direc	_	2 Name and Address tate Anato altimore,			Baltimo	re Street
	23a. Part Enter the disease, or conshock or heart failure. List only	plications that caused the	death. Do not en	ter the mode of dyin	g, such as cardia	c or respiratory ar	rest,	Approximate Interval Between
cian	Immediate Cause (Finat disease or condition		Y/Out 2	uten	20.			Onset and Death
lical	resulting in death)	Due to (or as a co						iyear
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a or	oneaquorieu of):					
Examiner	Cause. Enter Orderlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co	onceduance of):					
cai		d	orisaquarica ori).					
Med	IF FEMALE:							
should be detached for use as the should be detached for use as the should b	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of p 1 Live birth 2 C 4 Pregnant at tim 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th Day Year
Phy	Part II. Other significant conditions	contributing to death but n	ot resulting in the	Inderhing cause and	en in Part I	23e Did to	phacco use contri	bute to the cause of death?
Completed by		notic Cal				1	/	3 ☐ Probably 4 ☐ Unknown
I director, page 2 sho						24a. Was	an 24b. W	ere autopsy findings available for to completion of cause of
						perfo	rmed2 de	eath? □ Yes 2 □ No
Be (25. Was case referred to medical examiner?				26. Place of De	ath (Check only o	ne)	
유	t ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/Outpatie		4 La Nursing	Home 5 ☐ Resid		
tion: T	27. Manner of Death 1	28a. Date of Injury (Month, Day Ye	ear) 28b. Time (Worl	/at <br Yes 2 ∐No	28d. Describe h	now injury occurre	d
ed in by the funera Certification:	3 Suicide 6 Could not be determined	00 - 11	- At home, farm, si Specify)			28f. Location (S City or Tow		r or Rural Route Number,
Medical Cerl	29a, Certifier 1 Certifying Pl	nysician: To the best of m miner: On the basis of ex and manner stated	amination and/or in	th occurred at the time	ne, date and place pinion, death occ	e, and due to the curred at the time,	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
Me	29b. Signature and title of certifier	and manner stated		29c. License	number		29d. Date signed	(Month, Dey, Year)
8	Sanlan	Owere	me	00	1852	_	TUNE	11 2007
	Paul A. Del	LORE MA	42030	Print)	15 AURE	, ad H	tya TTS	5, 16 MD 200
State	31. Date filed (Month, Dey, Year) JUN 2 0 2	32. Registrar's		aus j				
egistrar								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, 2 Date of Death Day Month 1545 **Physician** RO 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS 8. Date of Birth (Month, Day, Ye) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Year. 1XM 2□F MARYLAND 1919 88 220-05-3426 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MARYLAND ANNE ARUNDEL MILLERSVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 844 GENERALS HIGHWAY 21108 UNITED STATES by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene. Is marked other than "natural", or Iter 1 ☐ Yes 2 🕅 If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. WHITE 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HORSE RACING HORSE TRAINER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ESTELLA LOWMAN HOWARD E. BOYER es 1 and 2 should be of Health and Mental Item 27 is marked ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 838 GENERALS HWY., MILLERSVILLE, MARYLAND 21108 CHARLES A. BOYER / SON 20b. Place of Disposition (Name of BALDWIN MEMORIAL METH. CH. CEMETERY JUNE 20. 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or otl 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 MILLERSVILLE, MARYLAND 4 ☐ tonatjon 5 ☐ Other (Specify) 22. Name and Address of Facility KIRKLEY-RUDDICK 421 CRAIN HWY., 21. Signature of Juneral S FUNERAL HOME, P.A. S.E., GLEN BURNIE, XIRKLEY-RUDDICK FUNERAL HOM 421 CRAIN HWY., S.E., GLEN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical 3 Examiner VISCUS u Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner the death certificate be executed signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE yes, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 1 🗆 Yes 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Medical Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Kicrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) JUN 2 0 2007

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

MAM 441 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 1^{Day} 2007 05:30 June Bunn Jr. Elias 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel 1747 Wood Carriage Way Severn | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Day) | Hours | Min. | 0.66 | 2.2 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 73 33 NC 216-16-0824 Usual Residence of Decede 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □Yes 2 No Anne Arundel Severn 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21144 U.S.A. <u>1747 Wood Carriage Way</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: Black 3€ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Balto City Housing 12th grade Maintenance Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charity Ann Bullock Elias Bunn Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1747 Wood Carriage Way, Severn, Md 21144 Phillip Bunn-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 6/23/07 Baltimore, Md Loudon Park 21. Si naturo of Funeral Service Licensee 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, Approximate Interval Between Onset and Death 23a. Pa. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s. ock, or heart failure. List only one cause on each line. I omer ate Cause (Final disesse or condition resulting in death) Sylars Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

permit. Page Department o Important: If any injury or once.

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be မ MD

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

Baltimore. Maryland 21215-0036

physician and s the burial-trans

Records, P.O. Box 68760.

Division or Vital

Examine Physician/Medical þ Completed Be Certification: To

4 ☐ Homicide

The law requires that the death certificate be executed signed by t certificate To the Hospital or Attending Physician: "
within 24 hours after death.

To the Funeral Director: After this certifical completaly filled in by the funeral director, p Medical

State Registrar

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 3a) (Type, Print)

PASAdena MD Magothy Beach Rd 24A M.D.

32. Registrar's Signature 31. Date filed (Month, Day, Year) JUN 2 0 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 5:04 p. M June 16 2007 Kenneth Watson Bosley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 417 Oakwood Road Dundalk 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex Year) **Funeral** Months Days Hours 1 M 2 □ F July 17, 73 1933 Director 219-28-8720 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d, inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director Baltimore Dundalk Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 United States 417 Oakwood Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Xyes 2 ☑ No 1952-If Yes, Give Year or Dates: 1953 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify. Specify: Completed by White 3 Widowed 4 Divorced 1953 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Building Construction 10 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie Fort Abraham Bosley ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21222 Kenneth Wayne Bosley (Son) 417 Oakwood Road 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/20/2007 Owings Mills, Maryland Garrison Forest VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 art1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or s a consequence of): Completed by Physician/Medical Examiner buriai-trans resulting in death) Last physician is the buria IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 4□Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 2**2** No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medical Certification: After To the Hospital or Attending within 24 hours after death. Injury 5 Pending investigation 1 Natural after death. I Director: Aid in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760%

Saltimore, Maryland 21215-0036

within 24 hours a To the Funeral C 141

29c, License number 29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause death (Item 23a) (Type, Print) House AllEN REILLY 1011

FREDERICK Md 21701

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

JUN 2 0 2007



🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 5130 17 M 07 Drown 6 W:1/20,00 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Berria 6. Sex Salhane Parkuille 8. Date of Birth (Month, Day, Year) 2-28-1920 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Min 1**M** 2□ F Months Hours Director death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ortant: If item 27 Is marked other than "natural", or items 23a or 28a-1 show injury or other traumatic event, the Madical Examinar must be nutified at 1 Yes 2 No 1 timore Director MD 10g. Citizen of What Country? 10e. Street and Number USA by Funerai permit. Pages 1 and 2 should be filled within 72 hours efter deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event. 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status orces? Black, White, etc. 1 Yes 2 I If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname hington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. Balto. MD 20a. Method of Disposition Burial 2 Cremation 3 R
4 Donation 5 Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of acting, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ASCUP 40005 /Medical Due to (or as a consequence of) Examiner G Pac 1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Din Due to (or as a consequence of) Examiner The law requires that the death certificate be executed for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 Ho 3 Probably 4 Unknown Bladelle Comier Completed 24b. Were autopsy findings available prior to completion of cause of death? renal failure - chamic 24a. Was an performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 ☐ Yes → No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural Injury 5 Pending after death. Director: Af 1 Yes investigation 2 Accident 3 Suicide Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31295 6/15/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

6 701

JUN 2 0 200

4202

N Charles St Suite

32. Registrar's Signature

200

70WSON

Registrar DHMH 17 Rev 1/200

State

MD

32. Registrar's Signature

MUNEYED

JUN 2 0

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mic	ai yiai io			ate of L		ila ivie		eg. No.	007	1978
	Physicia	an	1. Decedent's Name (First, Middle, L	ast)			7			2	Date of Deat	th	Year	3. Time of Death
	/Medic		Dolores					alle			June	Day	200	
	Examin	er	4a. Facility Name (If not institution, g						Location of	Death		4c. C	County of Dea	ith
	Funeral		Good Samaritan H 5. Social Security Number 6.	Sex 7. Ag	e (In yrs. la	st birthday)	l .	Ltimor ler 1 Year	If Under 2	4 Hrs. 8	. Date of Birth			thplace (State or Foreign
Ŀ	Director		215-30-2709 Usual Residence of Decedent	1□M 2ĂF	70	Yrs.	Month	s Days	Hours	Min.	(Month, Day, July 5,	, Year)	C	ountry) Yland
	ryland how at		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	he Ma 8a-f s	Funeral Director	Maryland N/A		Ba1t	imore								1 X Yes 2 No
	a or 2	Dir	10e. Street and Number 3910 E. Northern	Darkman				Zip Code 21206			1		en of What C	ountry?
	ms 23	nera	11. Marital Status	12. Was Decedent	Ever in U.S	13.			ispanic Origi	in? (Specif	fy Yes or No- can, etc.)		4. Race - Am	erican Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I have 23 or 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ 1 If Yes, Give Year or Dates:	No			pecify Cuba 2₩ No	n, Mexican, Specify:	Puèrto Rio	can, etc.)		Black, Whi	
5-0	"natu	etec	15. Decedent's (Specify only highest g	Education rade completed)		16a. Dece	dent's Us	sual Occupa work done o	ation during most	of working		16b. Kin	d of Business	/Industry
121	withigher withing the Me	Completed	Elementary/Secondary (0-12) 12th Grade	College (1-4or 5 n/a	i+)	House)			He	er own	home
	al Hyg other	Be C	17. Father's Name (First, Middle, Las						18. Mother	's Name (I	First, Middle, I			110.110
ylar	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Mi	To E	Lawrence Stolfo						Ange	line	DiFrar	nciso	20	
, Maryland	1 and 2 sho Health and Iem 27 Is m		19a. Informant's Name/Relationship Mr. George Bauer								ay Bal			
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	☐Removal from State		ace of Dispo metery, crei				Dat			ation - City o	
Him	permit. Pages ' Department of H Important: If ite any Injury or ot once.		4 ☐ Conation 5 ☐ Other (Special Signature of Funeral Service Lic		Cre	st La			. i	6/30/				lle, MD
Ba	permi Depar Impor any Ir) Joseph Co	CAA 5							al Home altimor			nd 21206
7.			23a. Part1. Enter the disease, or co shock or hear failure. List on	mplications that caused ly one cause on each lir	the death.								<u>laryra</u>	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a Meto		1			CLINO					Onset and Death two Wonths
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):	,	3			,			
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. — Due to (or as	a conseque	ence of):								
/	acuted nd transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
68760,	tificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as	a conseque	ence of):								
687	ficate physis the	Aedical		d										
Вох	eath certi attending for use a	M/LI	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			70-4					23	3d. Date of de	elivery
.O. B	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/	in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	4☐Pregnant at				pregnancy (specify)					Month	Day Year
<u>α</u>	es that igned by be deta	by Ph	Part II. Other significant conditions	contributing to death b	ut not resul	ting in the u	nderlyin	cause give	en in Part I.		23e. Did tol	bacco us	e contribute	to the cause of death?
ğ	w require been sig should b										1 🗷 Y	es 2□]No 3□F	robably 4 Unknown
Records,	has be	Completed									24a. Was a		24b. Were a	utopsy findings available completion of cause of
alF											performula 1 Yes	med? 2 ANo	death? 1 ☐ Ye	
Vital	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	000	'D/O		Othe	or.		Check only on			
0	g Phys er this eral dii		27. Manner of Death	1 A Inpatie	ry 2	R/Outpatier 28b. Time o		28c. Injury Work	4 LI Nurs		5 Reside			ecify)
ion	for Aft	atio	1 Natural 5 Pending 2 Accident investigati		y Year)	Injury	М		<br Yes 2 □ N	lo				
Division	sal or Attenders safter death	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At hon c. (Specify)	ne, farm, str	eet, fact	ory, office		281	f. Location (Si City or Town	treet and n, State)	Number or F	iural Route Number,
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical (29a. Certifier 1 CertifyIng I (Check only one)	Physician: To the best aminer: On the basis of and manner sta	f examination	rledge, deat on and/or in	h occurr vestigati	ed at the tin on, in my o	ne, date and pinion, deatl	d place, an	d due to the c l at the time, d	ause(s) a	and manner a place, and du	s stated. e to the cause(s)
	To the To the comp	ž	29b. Signature and title of certifier	0 000			2	9c. License			2			th, Day, Year)
			- Charles &	egettus)				DIZ	246			6/1	9/200	(
	10		30. Name and address of person who	o completed cause of d	eath (Item 2	23a) (Type,	Print)	lose	Rall	Merci	e, M	6 >	1239	
	Sta	te ar	31. Date filed (Menth, Day, Year)	32. Registra	ar'a Signatu	Charle	9	,		CFOCK)			

			Pleas				artment of H		-	_	le.
			For Stete Registrer	State 0	i iviai yiai		rtificate of			Reg. No.	7 19735
			Decedent's Name (First, Middle,	Last)					2. Date of De	ath	3. Time of Death
	Physici /Medic			Dolores		adley			June	Day	07 120 M
7	Examin	er	4a. Facility Name (If not institution,	give street and nur	mber)		4b. City, Tawn, or	r Location of Death		4c. County of	GRA Death
	Funeral Director		5. Social Security Number 212-22-4635	Sex 1 M 2 F	7. Age (In yrs. 81	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Feb. 1.	th y, Year) 5, 1926	Birthplace (State or Foreign Country) Maryland
	pug *		Usual Residence of Decedent 10a. State 10b. County			ty, Town or Lo	ocation				10d. Inside City Limits
	death with the Maryland ma 23a or 28a-f ehow must be notified at	ctor	Maryland Harf	ord		Belca					1 ☐ Yes 2X No
	with th	Director	10e. Street and Number	a			10f. Zip Code	-		10g. Citizen of Wh	•
	leath na 23	Funeral	1123 Belcamp 11. Marital Status	Garth 12. Was Dece	edent Ever in U	I.S. 13.	2101 Was Decedent of H		ecify Yes or No	U.S.A.	American Indian,
180 36		by Fun	1 Never Married 2 Married 3XXWidowed 4 Divorced	Armed Fo	rces?		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 【XNo	n, Mexican, Puerto Specify:	Rican, etc.)	Black, Specify:	White, etc. White
DO-21	72 h	Completed	15. Decedent's (Specify only highest	Education		(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of work	king	16b. Kind of Busi	ness/Industry
212	d withi	ошо	Elementary/Secondary (0-12) 8th. Grade	College (1	I-4or 5+)		omemaker	,,		Own Ho	me
Pu	be filed tal Hyg d othe	Be C	17. Father's Name (First, Middle, La	ist)			Q.III G.III G.I.	18. Mother's Nam	e (First, Middle	Maiden Surname)	
yla C	nould to a Ment narked natic e	To	Charles Thomas		ys			Helen			Noyes
i Raina (ith and th and treum		19a. Informant's Name/Relationship Debbie Ballweg		r		ng Address <i>(Street a</i> Declarat		al Route Number Belcam		ate, Zip Code) .017
€. je	s 1 and the all them 2 other		20a. Method of Disposition		20b. I	Place of Dispo	sition (Name of matory or other place		Date	20c. Location - C	
	Page nent o ant: If ary or		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				Cemetery		2007	Baltimor	e MD
Vì R Baltimore,	permit. Pages I and 2 should be flied within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than eny injury or other treumatic event, the Magnes.		21. Signature of Funeral Service Lie	Censee		22	Name and Address Miller 6415 P	ss of Facility -Dippel Belair Ro	Funeral	Home, In	nc. D 21206
			23a. Part1. Enter the disease, of the shock, or heart failure.	prefications that c	aused the deal	th. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	chra		enal F	alune			Onset and Death
	/Medical Examiner		resulting in dealin)	Due to ((or as a consec	(uence of):	100 / 00	- Do			
-		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quenc of):	Nthro	MANNY			4 ACM
V	be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с.	Bly	are t	milian				Year
760,	e be exersicien a	cal Ex	resulting in death) cast	Due to (or as a cons-	ce of):					100
687	ficate phys			d							
X	leath certificate attending phys I for use as the	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna		Ectopic pregnancy			23d. Date	of delivery
Division of Vital Records, P.O. Box 68	Attending Physicien: The law requires that the death certificate or death. cloath. ctor: After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the	by Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		ant at time of c		Other (specify)			Monti	n Day Year
ds, P	w requires that the di been signed by the should be detached	l by P	Part II. Other significant condition	s contributing to de	eath but not res	ulting in the u	nderlying cause give	en in Part I.			ute to the cause of death?
cor	w requ	letec	- min	n n,	6	. 1	110.0		24a. Was		are autopsy findings available
l Re	: The lay cate has	Completed	hrometh	MININ	prin	my de	JEASE		autor	osy prie	or to completion of cause of ath? Yes 2 No
Vita	sicien: Th certificate rector, pag	Be	25. Was case referred to medicat examiner?	Hospital:			Oth	26. Place of Deat			
of	y Phys ar this eral dir	n; To	1 Yes 2 No	28a. Date of	npatient 2 of Injury	28b. Time o	it 3 DOA	4 Nursing Ho		dence 6 Other	
ion	ath. r: Afte	atio	1 Natural 5 Pending 2 Accident investiga	1	th, Day Year)	Injury		k? Yes 2 □No			
Divis	al or Atter after de I Directo d in by th	Certification;	3 Suicide 6 Could no 4 Homicide determin	ad 289. Flace	of Injury - At h ng, etc. <i>(Specil</i>	ome, farm, str (y)	eet, factory, office		28f. Location (. City or To		or Rural Route Number,
	To the Hoepital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	teminer: On the ba	best of my kno asis of examina ner stated.	owiedge, deat ation and/or in	n occurred at the time vestigation, in my of	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and manr date and place, an	ner as stated. d due to the cause(s)
	To the To the complete	Me	29b. Signature and title of certifier	1112	ilam		29c. License	e number		29d. Date signed (Month, Day, Year)
	2		30. Name and address of person wh	no completed caus	e of death (Iter	n 23a) (Type,	Print)	114/)	6 (15/1	
	2		AAMA Mich	emp	61J1	non Pl	m) pd	Bel	Am)	un s	21014
	Sta Registr		31. Date filed (Month, Day, ¥ear)	2007	egistrar's Signa	ture 6	ule		, ,		
			WHI. (4.1)	The state of the s	NA TON	1					

ORIGINAL

baltimore, Maryland 21215	permit. Pages 1 and 2 should be filed within 72	important: if item 27 is marked other than "na
	Phy /N Exa	
or vital Records, P.O. Box 66/60,	g Physician: The law requires that the death certificate be executed	er this certificate has been signed by the attending physician and

		For State Registrar		State of	Maryland		artment of F				iene	07	19785
Physici		1. Decedent's Name		Last) ISON CLAR	K					Date of Dear Month	h Day	Year 007	3. Time of Death
/Medio Examin		PRINCE G	EORGE'S	give street and number) HOSPITAL CENTER			4b. City, Town, or Location of Death CHEVERLY				4c. County of Death PRINCE GEORGE'S		
be filed within 72 hours after death vial Hygiene. Ad other than "natural", or items 23sevent, the Medical Examiner must		5. Social Security Nu 579-42-984 Usual Residence of I	40	3. Sex 1	'. Age (In yrs. I	73 Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	Date of Birth (Month, Day, AY 9,		Cour	place (State or Foreign htry) HINGTON, DC
	ctor	10a. State	10b. County	GEORGE'S	10c. City	LANDO						1	0d. Inside City Limits 1 Yes 2 No
	To Be Completed by Funeral Director	11. Marital Status 1 Never Marrie 3 Widowed (Special Elementary/Secon 12 Tr 17. Father's Name (I JACK CI 19a. Informant's Nat KATHERI	THEW HEI ed 2 Married d □ Divorced 15. Decedent's fry only highest indary (0-12) Thirst, Middle, La LARK me/Relationship INE CLAI	If Yes, Give Year or Date Education grade completed) College (1-ast) p (Type. Print)	2 (2) No 3 (2) (2) (2) (2) (2) (3) (2) (3) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4	16a. Decedifice (Give life. 1	10f. Zip Code 20785 Nas Decedent of Harves, specify Cub I Yes 2010 I Yes 201	Specify. Dation during most during most d) SUPF 18. Moth DES1	c: ERVISOF Her's Name (Fi IREE CI Deer or Rural Re	Yes or No- an, etc.) R irst, Middle, I ARK oute Number	PRIVAMAIDE Surna	STATI ace - Americ ack, White, ify: BLAC Business/Inc ATE ame) n, State, Zip	ES can Indian, etc. CK dustry c Code)
permit. Pages 1 Department of Hi important: if iter any Injury or oth		20a. Method of Dispo 1X78urial 2 4 Donation 21. Signature of Fur	☐Cremation 3 5 ☐ Other (Spe	-	tate C	lace of Dispo emetery, crer LINCO	sition (Name of natory or other pla DLN CEMET Name and Addre	ERY	6-25-0	o7 tol Mo	Lando	over, over, over,	Md.
Physician /Medical / Examiner the prival-transit	dical Examiner	23a. Papt. Enter the shock, or hear Immediate Cause (F disease or condition resulting in death) Sequentially list confirmany, leading to implease. Enter Under Cause. Enter Under Cause (Disease or it that initiated events resulting in death) Li	t failure. Ust o Final I Iditions, mediate dying	a. CONDUCTOR Due to (c) b. MYEL Due to (c) c. LUNC Due to (c)	on as a consequence of the conse	IRTERY uence of): FERATI uence of): ER uence of):	DISEASE VE DISEA	SE			951,		Approximate Interval Between Onset and Death
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other signifi	months?] No	4□Pregna 9□Unkno	rth 2 ☐ Fetal ant at time of do wn	I death 3 ace ath 5	Ectopic pregnanc Other (specify)		I.	23e. Did to	N.	eate of deliver	ery Day Year he cause of death?
sician: The law require s certificate has been sig irector, page 2 should b	Be Completed b	25. Was case refern	red to medical					26 Plac	ee of Death (C		n 24b sy med? 2 X lo	. Were auto prior to co death?	posphy 4 Unknown posy findings available mpletion of cause of 2 No
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate in completely filled in by the funeral director, page	Certification: To B	examiner? 1 Yes 2x 1 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide		28a. Date o (Month	f Injury o, Day Year)	ER/Outpatier 28b. Time of Injury ome, farm, str	28c. Inju Wo	ner: 4□N	lursing Home 28d	5 ☐ Reside	ence 6 🗆 O	urred	fy) al Route Number,
To the Hospita within 24 hours To the Funeral completely filled	Medical C	UNE)		Physician: To the laxaminer: On the ba	best of my kno sis of examina er stated.	wiedge, deatl tion and/or in	n occurred at the ti vestigation, in my		and place, and eath occurred				
_	~	29b. Signature and the second		tho completed cause	M ⊳	1 23a) (Type	D0	05763	36	2	9d. Date sigr	e 18,	
Sta Registi	_				•		,	y, Md	207	85			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Man		epartment of I		Mental Hygie	6001	15737
			Decedent's Name (First, Middle	Last)				2. Date of Death		3. Time of Death
	Physici		TIM OH+Y	BYRON	CC	NHING		.man J'	Day Year	1950M
	/Medic Examin	_	4a. Facility Name (If not institution,			4b. City, Town, o	or Location of Deat		4c. County of Death	
	LAdillii	-1	19/10/ 120		as	1-1-ACMIN	Stowe	1	WASIT	ington
	Funeral		5. Social Security Number	6. Sex 7. Age (/	n yrs. last birt	hday) If Under Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign
	Director		21978 2903	1 2X M 2□F	19	rs. Months Days	Hours Min.	Month, Day, Ye	-55 Col	^{intry)} unk
٠,		ľ	Usual Residence of Decedent							
	how i		10a. State 10b. County	10	Dc. City, Town				and the second	10d. Inside City Limits
	e Ma	Sto	MD Washi	ngton	Hage	erstown				1 ☐ Yes 2⁄ ☐ No
	or 28	lre.	10e. Street and Number			10f. Zip Code	217		Citizen of What Cor USA	intry?
	be lied within 72 hours after death with the Maryland Hygiene. Hygiene. d other than 'naturel', or items 23a or 28e-f show event, it a Medical Evantinar must be notified all	Funeral Director	18601 Roxbury I				217	42	USA	
-	dea	ner	11. Marital Status un	12. Was Decedent Eve Armed Forces?	or in U.S.	13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
٥	or It	Ŧ	1 Never Married 2 Marri	If Yes, Give		1 ☐ Yes 2 No			Specify: W	hite
9	irel'.	d by	3 Widowed 4 Divorced	Year or Dates:						
9500-61212	nat	Completed	15. Decedent (Specify only highes	s Education t grade completed)	16a.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of wor	_{king} unk 161	b. Kind of Business/l	ndustry unk
7	han in	E D	Elementary/Secondary (0-12)	College (1-4or 5+)		ille. DO NOT use retire	10)			
7	Hygie Hygie Ather I	ပိ	unk 17. Father's Name (First, Middle, I	unk		unk	18 Mother's Nat	ne (First, Middle, Mai	iden Sumame)	unk
_	m = 0 5	Be	17. Facility Strains (Final, Micolo,			unk		1. 101, 1110010; 112		ulik
َ جَ	should be ind Mental imarked c	ဥ	19a. Informant's Name/Relationsh	in (Time Briet)	10h	Mailing Address (Stree	and Number or B	ural Paula Number C	ity or Tourn State 7	in Code)
Maryland	h and h and		MCI Hagerstown			18601 Roxbu				_
a)	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.	-	20a. Method of Disposition			Disposition (Name of			c. Location - City or	Town State
Ö	Pages nent of h nnt: If It		1 Burial 2 Cremation	3 □Removal from State		y, crematory or other pla	се)			
altimore,	t. Pa tmer tant dury		* 4 □ Donation 5 🖾 Other (Sp	07			A Facility			
Ra	permit. Departr Imports any inje		21. Signal re of Euneral Arvice L Konald	Ware, Direc	tor	State Anat	omy Boar	d 655 W. B	altimore	Street
	40240		23a. Part1. Enter the disease, or	1/1/2000	a death Dea	Baltimore,				Approximate
- L	The private and the private an	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	Onsequence of S	of): NOSIS	Nerma)cystis	CAPINII	Onset and Death
89	ficate p phy s the		3	U	77					
O. Box	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 { 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	y		23d. Date of deli Month	very Day Year
ທິ	res that igned b be deta	by Pl	Part II. Dther significant condition	ns contributing to death but r	not resulting in	the underlying cause g	ven in Part I.		co use contribute to	
Records,	v require been sij should b		# 10	may con	7014			1 Tes	2 No 3 Pro	obably 4 Dunknown
ပ္က	aw re as be 2 sh	Completed	HCV	METT	140			24a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of
ř	The law	Eo	100	50				performe	d? death?	2 No
<u>E</u>	ilcien: Th certificate rector, pag	BeC	25. Was case referred to medical				26. Place of De	ath (Check only one)	20	
Division of Vital	ng Phys Iter this neral dii	၉	examiner? 1 Yes No 27. Manner of Death 1 Natural 5 Pendin	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Y		ime of 28c. Injury	ry at ork?	lome 5 ☐ Residence 28d. Describe how		IN THRUAR
S	Attending ir death. ector: After by the fune	cat	2 Accident investig 3 Suicide 6 Could r	ot he	411]Yes 2□No	206 Lanatina (Chan		-1.B t- Nt
≥ :		Certification:	4 Homicide determ		Specify)	rm, street, factory, office		City or Town, S	et and Number or Ru State)	rai Houte Number,
_	To the Hospitel of within 24 hours at To the Funeral D completely filled it		29a. Certifier 1 Certifyin	g Physician: To the best of r	ny knowlada	dath populated at the	ma data and alco-	and due to the service	co(e) and masses	etated
	To the Hospitel within 24 hours a To the Funeral i completely filled	Medical		Examiner: On the basis of examiner state	camination an					
	thin ; ithin ; or the	Me	29b. Signature and title of course	and mainer states		29c. Licen	se number	29d	. Date signed (Month	n, Day, Year)
	E ₹ 8	Inili		JOBANII	a	Ê	VILLETA	h		
			20 Name and address	the completed	h (lio = 22=1	Tuno Brian	744 6	(-1	00 -10	
			30. Name and address of person	Property of the completed suse of deal	I A (IIII 23a)	186	OI KOX	BURY RI	O. HAGRE	0-07 Brown, 4
	Sta	to.	31. Date filed (Month, Day, Year)	32. Resistrar's	Signature					
	Regist			0 2007 Place	. 1	Coralis				

7-04576 Denise Claxton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

25	13		0.117		
()	11	1 1	2		
f.	U		7		1

36	ype of fille life	and Montal Hya	ion
	State of Maryland / Department of Health	and Mental Hyg	ICII
	Certificate of Death		

	D	egistrar			incate of			2. Date of Dea	ath	3.	. Time of Death
hysicia		I. Decedent's Name (First, Middle	e,Last)					, Month June 15,	Day Y	ear	1132 hrs
Exami	ner	Denise Clax	kton				tion of			ty of Death	
	4	4a. Facility Name (if not institution	n, give street and nu	umber)		4b. City, Town, or Education of Beauti					
		Good Samaritan Hosp				Baltimore				VVV II Diet	place (State or
		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year			irth(MM/DD/YY	Foreign	Maryland (state of Maryland
Funeral	Ι,	o. Social Security Names			Yr	Months Days	Hours	Min. 01 /15	/1959	Coun	try)
Director	- 1	213-82-4642	1 M 2X F	48_	11;	s	100	101/15	11937		
		Usual Residence of Decedent		100 City	Town or Loca	ition				1	I 0d. Inside City Limits
an A		10a. State 10b. County		Toc. City,						1	1 X Yes 2 No
id how	ايد	Marriand			Balti				10g. Citizen of	What Count	rv?
daryland 28a-f show datonce.	용	Maryland 10e. Street and Number				10f. Zip Code			_		
Ma or 28	Director					212	234	_ X.	U.S.F		
after death with the Maryland 'al'', or items 23a or 28a-f sho iner must be notified at once.		6618 Ellsmere	Place	ecedent Ever in U.	.S. 13. W	as Decedent of His	panic Origi	n? (Specify Yes or I			an Indian, Black,
h wit	Funeral	11. Marital Status 1 Never Married 2 M		Forces?	If	Yes, specify Cubar	, Mexican,	Puerto Rican, etc.)	, v	/hite, etc.	
deat or ite	اج		1 Yes	2 X No	1	Yes 2 X No	specify:	*	Spec	ify: Blac	ck
after all', o	Ş.		vorced If Yes, Give Y			ent's Usual Occupa		ind of work done	16b. Kind o	f Business/In	
ntur	g	15. Decedent's Education (Spe			during	most of working life	. DO NOT	use retired)			
2 ho	Completed	Elementary/Secondary (0-12)) College	(1-4 or 5+)					G =		
36 hin 36 than	힐		2+		Sec	urity Of	ficer	s Name (First, Middle	Sect	rity	
d wit	ĕ	17. Father's Name (First, Middle	e, Last)								
215-0036 be filed within 72 hours mial Hygiene. rked other than "natur vent, the Medical Exam	Be	Leonard Baile					Bern	ice Satter ober or Rural Route N	field	<u>Bailey</u>	7: 0-4-)
	0 E	19a. Informant's Name/Relation	nship (Type, Print)		19b. Mail	ing Address (Stre	et and Num	ber or Rural Route N	Number, City or	Town, State,	, Zip Code)
, MD 21 and 2 should lealth and Me tem 27 is ma traumatic es	-			~~	108	Broadway	Road	Reisters	cown, Ma	arylan	d 21234
MD od 2 sho alth and m 27 is		Rhonda Stutts 20a. Method of Disposition	/ Daughte	20b.	. Place of Disp	position (Name of ce	emetery,	Date	20c. Loca	tion - City or	Town, State
nore, MD 2: ages 1 and 2 should not of Health and M nt: If item 27 is m		1 Burial 2 Cremation	on 3 Remova	I from State	crematory or	other place)			_		14
nt o ages	1	4 Donation 5 Other		K	ing Mer	norial Pa	rk				Maryland
Baltimore, permit. Pages 1 and Department of Heal Important: If item injury or other fra		21 Signature of Funeral Service	ce Licensee		22	2. Name and Addres	ss of Facilit	THE PELL	ick C.	Jones	F/H, Р.А. yland 21215
Deprint	·	12	6.14			4611 Park	Hats	Ave. B	altimor	<u>e Mar</u>	Approximate Interval
	_	23a. Part I. Enter the disease,	or complications that	at caused the deat	h. Do not ente	er the mode of dyin	g, such as o	cardiac or respiratory	arrest, shock,	or neart	Between Onset and
ysicia: /Medica		failure. List only one caus	se on each line.								Death
Examine		Immediate Cause (Final diseas or condition resulting in death)	se a. Pneum	orma as a consequence	of).						
		or condition resulting in death,) Due to (or a	as a consequence	01).						
	_ ا	Sequentially list conditions,	Due to (or	as a consequence	of):			4			
	ner	if any, leading to immediate cause. Enter Underlying Cause	se	23 2 0011004001100				*			
	Examin	(Disease or injury that initiated events resulting in death) Las	Due to (or	as a consequence	of):						
p ·	i \ ŏ	events resulting in death) Las	d								
8760, tifficate be executed ng physician and				FD on No	060	7/12/07 9					
be ex	n/Medical	X UNPENDED	— ^"#23x	a,2/,perML	, g809,	7/12/07 TT			23d. E	ate of delive	ry
68760, certificate be nding physic	E S	IF FEMALE: 23b. Was decedent pregnant i	in the 23c. If y	es, outcome of prive birth		Fetal death	3 Ector	oic pregnancy	Mo	onth	Day Year
α - =	as as	past 12 months?		regnant at time of	death 5	Other (Specify)			1		
atten	Si us	1 Yes 2 No 9		Inknown	3	Office (Opcomy)					
the der	Dhysicia	Part II. Other significant cor			nt resulting in	the underlying caus	se given in !				to the cause of death?
at th	etach		aditions contributi	ing to death but in	J. 100-1111	, ,		1	Yes 2 🗸	lo 3 Pr	obably 4 Unknown
Division of Vital Records, P.O. Box 68. Interpretation of Vital Records, P.O. Box 68. Interpretation of Vital Records, P.O. Box 68. In Director: After this certificate has been signed by the attending	be det							24a	Was an	24b. Were	autops y findings available
ds equii	pluo \$								autopsy	prior to	o completion of cause of
aw r has b	2 sh	<u> </u>							performed? Yes 2 No	death? 1 ✔	
ec The 1	age	5				00.0	lass of Doo	th (Check only one)			
F. ii	tor, p	25. Was case referred to me			_		Other		5 Residence	e 6 Ott	her:
/ita sicia sis ce	direc	examiner?	Hospital: 1	Inpatient 2	✓ ER/Outpa				cribe how injury		
Phy ter th	eral H	27 Manner of Death	28a.	Date of Injury (Month, Day, Year)	28b. Tim		Injury at W		cribe flow injury	occurred	
n C ding	fg.	Natural 5	Pending	(MOTHIT, Day, 1941)	ł	1	Yes 2				
ivision for Attend after death. Director:	y the	2 Accident		Place of Injury -	At home, farm	, street, factory, offi	ce building	, etc. 28f. Loca	ation (Street an	Number or	Rural Route Number, City
Vis or A Oire	E .	3 Suicide 6	Could not be					ori	own, State)		
.5 5 9	filled in by the funeral director, page 2 should	4 Homicide		ecify)			o deto and	place and due to th	e cause(s) and	manner as s	tated.
D Hospital 24 hours Funeral	· >		ng Physician: To th	ne best of my know	wledge, death	occurred at the tim	e, gate and inion, death	place, and due to the control occurred at the time	e, date and place	e, and due to	the cause(s)
To the To the To the To the T	completely	(Check only one) 2 Medical 29b. Signature and title of co	Examiner:On the I	basis of examinati nner stated.	on and/or inve	estigation, in my op	IIIIOII, deat	Tocodinos et are time			Month, Day, Year)
F With	100	29b. Signature and title of co				29c. Li	cense num	per			
7.	1	1/1/1.1		11.1		0	.C.M.E.		June	16, 2007	
		Cert	vues	VVI)	(Ham 22a)						
Λ,		30. Name and address of pe	erson who complete	ed cause of death	(item 238)	Penn Street, B	altimore	MD 21201			
V		Laron Locke MD.		edical Examir		, of the other of					
	Sta	ate 31. Date filed (Month, Day,)	Year) 2007	32 egistrar's Si	gnatu	San Contract					
	aist	HIN 2	0 2007	No. of Lot	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2'38A M RUMMONG JONALG 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) BALT MORE CINTER AMEdiCAL BALTIMUREV 8. Date of Birth Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Min 216-58-4628 1**№** M 2□ F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No NIA 10g. Citizen of What Country? 10e. Street and Number Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Maritat Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) FRANCINE DRUMMOND WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition 20c. Location 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DELIRIUM TREMENS Due to (or as a consequence of): ALCOHOL WITHDRAWAL if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 DUnknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy gerformed? 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 28b. Time of 28d. Describe how injury occurred

rsicien and The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. attending physicien as the esn ŏ ned by the a signed by it has page 2 certificate To the Hospitel or Attending Physician: this After thi funeral setter death.
I Director: A
d in by the fu death. within 24 hours eft To the Funerel Di completely filled in

Physician

/Medical

Examiner

10a State

Directo

Funeral

Completed by

Be ٥

Examine

Physician/Medical

À

Completed

Be

၉

Medical Certification:

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mantal Hygiene.
sent of the 27 is marked other then "natural", or items 23a or 28a-1 show and 10 other traumatic event, in a Marice Example mant be notified at

Importent: if item.
any injury or other

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0036

☐Yes 2☐No 9 Unknown 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No 27. Manner of Death 1 Natural

5 Pending investigation 2 Accident 6 Could not be 3 Suicide 4 - Homicide

28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MD

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

P17740

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DALAL, MD

10 NGREENESTREET BALLIMORE. MU 21201

State Registrar

2007



541

07-04578 John

M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 (979)

n Ernest Dudi		- For State Of Maryland / Department of Certificate of	Death	Reg. No.
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Month	Day Year 1220 bro
Examir	er	John E. Dudley	June 1 4b. City, Town, or Location of Death	5, 2007 1220 1113
		4a. Facility Name (if not institution, give street and number)	Rosedale	Baltimore County
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. 8. Date of	of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Funeral Director		213-72-2300 1XM 2 F 51 Yrs	Months Days Hours Min. Feb	.8,1956 Country) MD
	+	Usual Residence of Decedent		10d. Inside City Limits
v any		10a. State 10b. County 10c. City, Town or Loca		1 Yes 2x No
land -f shov	ē	MD Balelmore	10f. Zip Code	10g. Citizen of What Country?
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland neur of Health and Mental Hygiene, neur of Health and Mental Hygiene, art filtem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 5224 King Arthur Circle	21237	USA
s 23a		11. Marital Status 12. Was Decedent Ever in U.S. 13. W	las Decedent of Hispanic Origin? (Specify Yes Yes, specify Cuban, Mexican, Puerto Rican, etc	or No- 14. Race - American Indian, Black, White, etc.
death v r item nust b	Funeral	1 Never Married 2 Married 1 Yes 2 X No		Specify: White
after	by F	or Dates:	Yes 2 X No specify: ent's Usual Occupation (Give kind of work done	
2 hours "natu	ted	duning	most of working life. DO NOT use retired) penter	Local Union 0491
1215-0036 Id be filed within 72 hours Aental Hygiene. narked other than "natur event, the Medical Exam	Completed	12th	18.Mother's Name (First, Mi	Helian Surnama)
5-0(led wi liygien lother the M	ပ္ပ	17. Father's Name (First, Middle, Last)		. Whetstone
121 d be fi fental narked event,	o Be	George E. Dudley 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rural Rou	te Number, City or Town, State, Zip Code)
ID 2 2 shoul and N 27 is n	2	Robin Poole /sister 27	18 Clayton Road Jo	ppa MD 21085
e, N 1 and 2 Health item		20a. Method of Disposition	other place)	
MOF Pages ent of int: If		4 Donation 5 Other Specify:	t Cemetery 6/20/	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or other traumatic event, the Mediupy or other traumatic event,		21. Signature of Funeral Service Livensee		Mace Ave. Balto. MD
	_	23a Part I. Enter the disease, or complications that caused the death. Do not enter	Connelly Funeral H or the mode of dying, such as cardiac or respirat	tory arrest, shock, or heart Between Doset and
nysician Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic cardiov		Death
Examine		or condition resulting in death) Due to (or as a consequence of):		
	Į.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	i i	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of):		
147	Exa	events resulting in death) Last Due to (or as a consequence or).		
Records, P.O. Box 68760, The law requires that the death certificate be executed from the second of the action of the second of	ica	X UNPENDED AMENDED 7/20,27, perME. 2869. 7/	19/07 TT	
760, cate be exe physician he burial -	cian/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2	Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
Sox 6876 leath certificate e attending phy	jan	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2	Other (Specify)	
Box death	; i 'ū	1 Yes 2 No 9 Unknown a Unknown	have declared course given in Part I 23	Be. Did tobacco use contribute to the cause of death?
cords, P.O. Be law requires that the de has been signed by the	2		He didentified cadde given in the contract	1 Yes 2 No 3 Probably 4 Unknown
S, F quires en sign	7		24	4a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
SOFC law re	bage 2 should be		11/	performed? death? ✓ Yes 2 No 1 ✓ Yes 2 No
Re(The ficate	pag		26.Place of Death (Check only on	
/ital sician is cert	Dalliection	Do 2.5 Was case telefied to include: 0 examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa		
of Vital Recing Physician: The	<u> </u>	27 Mapper of Death 28a. Date of Injury 28b. Time	e of Injury 28c. Injury at Work? 28d. D	Describe how injury occurred
ion Itendir leath.	the ru	1 X Natural 5 Pending Investigation 28e. Place of Injury - At home, farm,		ocation (Street and Number or Rural Route Number, City
Division of Vital Records, tal or Attending Physician: The law requir rs after death.	d in b	1 X Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify) 1 X Natural 5 Pending (Month, Day, Year) 28e. Place of Injury - At home, farm, (Specify)		or Town, State)
Divisior Hospital or Attend 24 hours after death Funeral Director:			occurred at the time, date and place, and due to	the cause(s) and manner as stated.
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certiff	completely	29b. Signature and title of certifier 29c. Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or invegand manner stated. 29b. Signature and title of certifier	stigation, in my opinion, death occurred at the ti	29d. Date signed (Month, Day, Year)
J & J	3	29b. Signature and title of certifier	29c. License number O.C.M.E.	June 16, 2007
-		Mayorte Me Wrell	U.C.IVI.L.	
0		30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 1	11 Penn Street, Baltimore, MD 2120	01
	Sta	Wargarita (Eroli M.D.	oset	
Red		111N 2 0 200/ 200/ 200/		BOLE .

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Joseph B. Droll, Jr. **Physician** 2007 8:25 P M 17 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Lorien Nursing Home Mount Airy Carroll If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 X M 2 □ F Maryland 92 15, 1915 212-07-7544 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ant: If item 27 is marked other than "natural", or Items 25a or 28a-f show ant: If item 27 is marked other than "natural be notified at any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 1 NYes 2 □ No Director Maryland Carroll Mount Airy 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number is 23a c must t 713 Midway Avenue 21771 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black. White, etc. 1 ☐ Yes 21X No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify þ 3XWidowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) the M Elementary/Secondary (0-12) College (1-4or 5+) Printer Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph B. Droll, Sr. Cornelia Hartmann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other trace Nancy Dankanich / Daughter 15607 Thistle Downs Ct. Woodbine, MD 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 18. 20a. Method of Disposition 1 ☐ Burial 2 ICremation 3 ☐ Removal from State Resthaven Crematory Frederick, Maryland 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furnity Service Lines Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part1. Enter the disease shock, or heart failur. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** End Stage Congestive Heart Failure /Medical Due to (or as a consequence of): Examiner Yrs. Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Yrs. Atrial Fibrillation Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical Anemia of Chronic Disease Yrs. 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Metabolic Bone Disease, Hypothyroidism, Chronic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Airway Obstruction, Hypoalbumin, Gait Disorder, autopsy performed 1 Yes 2 No Arthritis 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA after death.

I Director: After this d in by the funeral di 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: (Month, Day Year) 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 24 hours a 1XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fil 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 30. Name and address of person who completed cause of feeth (Item 23a) (Type, Print)

Allen Reilly, M.D. 801 Toll House Ave., D-1, Frederick, MD 21701 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



29c. License number

D 54749

29d. Date signed (Month, Day, Year)

June 18, 2007

			Please T amend i	ype or Print in Black I	ndelible Ink. Ensure All part doc 2869 7-3-07 partment of Health and Me	Copies Are	Legible.
			For State Registrar		ertificate of Death	Reg. N	-001 1212
			1. Decedent's Name (First, Middle, Last)	~	4	2. Date of Death	3. Time of Death
B	Physici /Medio		Kalph Thon	198 Davis].	T	ay Year 3:24 pm
	Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Death	4	c. County of Death
			GOOD SAMARIT		BALTIMORE		λ Α
	Funeral Director		5. Social Security Number 6. Sex 220. 36. 6823 Usual Residence of Decedent	M 2□F 7. Age (In yrs. last birthda	Months Days Hours Min.	Date of Birth (Month, Day, Year 07 31 9	9. Birthplace (State or Foreign Country) MD
	/land		10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	Many Hang	ţ	MD N/A	Ba	ltimore		1 → Yes 2 □ No
	3a or 28e	I Director	10e. Street and Number	treet Apt. B	10f. Zip Code 21218	10g. C	Citizen of What Country?
	death ms 2	Funeral			Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	ify Yes or No-	14. Race - American Indian,
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event. If a Medical Exaction must be neithed at	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Xes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto H	can, etc.)	Specify: Black
ر ک	72 h inatu	ete	15. Decedent's Educ (Specify only highest grade	completed) (G	cedent's Usual Occupation ive kind of work done during most of work done during most of working		Kind of Business/Industry
2121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	a. DO NOT use retired) SUDEVVISOV	N	Varehouse
	filed withi Hygiene. other than	e Co	17. Father's Name (First, Middle, Last)	10/#	18. Mother's Name (
Maryland	d be ental	To Be	Lawrence Davis	5	Cecelia		
<u></u>	and Mental is marked of sumatic svi	ř	19a. Informant's Name/Relationship (Ty)		ailing Address (Street and Number or Rural		
	and 2 ealth a n 27 is		Phullis Davis / W	JiAU 152	OF. 36Th Street A	pt BP	alto MD 21218
ō,	ges 1 and 2 t of Health If item 27 i or other tra		20a. Method of Disposition	1 comptant of	sposition (Name of Da Prematory or other place)	te 20c.	Location - City or Town, State
Ë	op ∪ •		¹ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		101 OV	whopmill mo
Baltimore,	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service License		22. Name and Address of Facility Vau	glin C. Gr	
П			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death. Do not	enter the mode of dying, such as cardiac or		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	PULMONE	ARY EMBOLISM	A	Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of):	INT EMBORIST		
L	Examiner		Sequentially list conditions	BLADDE	ER CANCER		
	p #	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence or):			
	icate be executed physician and s the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last				
90,	oe exection and and and and and and and and and an	_	resulting in deathy cast	Due to (or as a consequence of):			
9289	cate b	dica	d				
9 ×	certificate be Iding physicia Ise as the bur	/Me	IF FEMALE:	3c. If yes, outcome of pregnancy			Ond Data of delivery
œ.	death e atter id for u	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
S,	s that ned b	by Ph	Part II. Other significant conditions con	tributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
rds	n sign					1 ☐ Yes	2 No 3 Probably 4X Unknown
Record	The law requires that the tee has been signed by thoage 2 should be detache	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
		မ လ	25. Was case referred to medical		00.00	performed?	No 1 ☐ Yes 2 ☑ No
5	Physician: this certific ral director,	o B	examiner?	ospital: 1 Minpatient 2 ER/Outpa	26. Place of Death		6 □Other (Specify)
	g Phy er this eral c	H	27. Manner of Death	28a. Date of Injury 28b. Time	e of 28c. Injury at 28	d. Describe how inj	
0	Attending in death.	atlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injur	y work? M 1 ☐ Yes 2 ☐ No		
Division	를 다 를 다	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	Bf. Location (Street and City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or within 24 hours afte To the Funeral Director completely filled in I	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knowledge, di ner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place, ar r investigation, in my opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as stated. ind place, and due to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier		29c. License number	29d. D	Date signed (Month, Day, Year)
	<		A COUNTY OF	GHOSH	RES - 000	1 31	UNE 16 2007
6	, 1		30. Name and address of person who co		pe, Print)		

State Registrar 31. Date filed (Month, Day, Year)
JUN 2 0 2007

3 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2007 EWAKT UNP /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner UTURE CARE hosapeake If Under 24 Hrs. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day 0Ct. 19 **Funeral** ^{Year)}919 Months Days Min 1 M 2 □ F 212-09-8208 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits a or 28a-f show be notified at 28a-f show 1 ☐ Yes 2 ☑ No Pasadena Directo Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 7978 Catherine Avenye USA items 23a Examiner must by Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 'natural', or 1 ☐ Yes 2 ☑ No Specify Specify: White 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Warehouseman Chemical Company and Mental Hygi 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Mary Ε. Della Ε. Chaney 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health sitem 27 is 7976 Catherine Avenue, Pasadena, MD 21122 Linda M. Sturgill (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of F Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State June 4 Donation 5 Dother (Specify) Glen Haven Cemetery 2007 Glen Burnie, Maryland of Funeral Service Lice isee 21. Sign Ju Stallings Funeral Home, 3111 Mountain Road, Pasadena, MD 21122 0 ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. 23a. Parl1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final DISCASE **Physician** RENAL VOBRE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner anding physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ate has been signed by the a page 2 should be detached 1 □ Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 STROKE 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed INE SEPSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform After this certificate 2 No 2□ No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Tyes 2 No ပို 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending (Month, Day 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Box 68760, P.O. The law requires that Division or Vital Records,

3altimore, Maryland 21215-0036

the death certificate be executed spital or Attendi nours after death. neral Director: A To the Hospital of within 24 hours aff To the Funeral D completely filled in

10+1

State Registrar 29b. Signature and title of certifie

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name at

PERNOS HIGHWAY MILLERNIUL, MD 21108

Ó 2007

(Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and N 1- State Registrar Certificate of Death	Mental Hyg	iene	9791
	Physici		1. Decedent's Name (First, Middle, Last) Claytan E. Durham	2. Date of Death	Is 0	3. Time of Death 7 08:20 AM
}	/Medio Examin	ier	4a. Facility. Name (It nownstitution, give street and number) Baltimore Rehabilitation & Extended are Conter Bultim	ar MI	4c. County of De	eath // Birthplace (State or Foreign
	Funeral Director		5. Social Security Number 238 84 7147 Usual Residence of Decedent 6. Sex 1	8. Date of Birth (Month, Day, MAY 20	,1950 NO	SRIPH AROLINA
	Maryland If show	tor	10a. State 10b. County 10c. City, Town or Location MD. N/A BALTIMORE			10d. Inside City Limits 1 □Xes 2 □ No
	with the	Funeral Director	10e. Street and Number 706 W. DOLPHIN STREET 21217	10	0g. Citizen of What USA	Country?
980	d within 72 hours after death with the Maryland jiene. I than "natural", or Items 23a or 28a-f show The Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ▼ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 14. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto If Yes, Specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:	pecify Yes or No- Rican, etc.)	Black, W	merican Indian, hite _≬ etc. BLACK
21215-0036	within 72 iene. r than "ne the Medic	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) Coflege (1-4or 5+) Coflege (1-4or 5+) Coflege (1-4or 5+) Coflege (1-4or 5+) Coflege (1-4or 5+) Coflege (1-4or 5+) Coflege (1-4or 5+)	ang	HOSPI!	
Maryland 2	be filed tal Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Last) UNKNOWN 18. Mother's Nam FAYE D	ur HAM		To Code
	is 1 and 2 of Health a ltem 27 to other trai		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 3 □Removal from State	APT.2D	BALTO I	MD. 21206
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Sponture of Funeral Service Licensee 22. Name and Address of Facility CALVIN B. SCRUC	GGS FUN		ME
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart faifure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions.		əst,	Approximate Interval Between Onset and Death
68760,	cete be executed by sician and the burial-transit	dical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): d.			
.O. Box	The law requires thet the death certificets tie has been signed by the ettending phy orge 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of Month	delivery Day Year
Ω,	w requires that been signed b should be deta	þ	Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			e to the cause of death? Probably 4 Unknown
al Records,		Completed			ned? deatr	autopsy findings available to completion of cause of 1? Yes 2 No
sion of Vital	Attending Physician: Thir death. ector: After this certificate by the funeral director, peg	atlon: To Be	examiner? 1 Yes Year) No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hospital: 1 Sea Date of Injury (Month, Day Year) 27. Manner of Pending (Month, Day Year) 1 Natural 5 Pending (Month, Day Year) 28. Date of Injury (Month, Day Year) 28. Date of Injury (Month, Day Year)	th (Check only on ome 5 Reside 28d. Describe ho		specifyHospice
Division	in the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St City or Town		r Rural Route Number,
	To the Hospitel or Ati within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	rred at the time, d	ate and place, and	due to the cause(s)
)	To the within 2 To the complei	Σ	29b. Signature and time of certified and the control of Certified Contro	/	9d. Date signed (M 06/15	107
1+	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print). Charks M. Harrison MD 3900 Loch Raven Blod. 31. Date filed (Month, Day, Year) 22. Registrar's Signature	Baltin	roems	21218
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 10 2 0 2007			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 19,2007 Month **Physician** Phvllis M. Frankus June 3:15A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8 Beehive Place Apt. Cockevsville Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 01.11.1930 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 DM MD 215.24.9646 77 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 □Yes 2 TNo Director MD Baltimore Cockeysville 10g. Citizen of What Country? 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be r 12. Was Decedent Ever in U.S Armed Forces? 8 Beehive Place Funeral 21030 Α 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itea any Injury or other traumatic event, the Medical Examines 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Mever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ 3 Widowed 4 □ Divorced Specify: White Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Robert Cornelius Laura Mae Eichelberger ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) sister 6128 Old Brentford Ct. Alexandria, VĀ Sylvia Barnhart-Gerben/ 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Chesapeake Crem. 06.20.07 Beltsville, MD 22. Name and Address of Facility Cremation And Funeral Balto 21. Signature of Funeral Service Licensee Moly 3 Alternatives 8717 Green 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pastures Dr. MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last Division or Vital Records, P.O. Box 68760, burial-tran Due to (or as a consequence of): Physician/Medical the attending phase as the 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the 9 Unknown 9 Unknown ate has been signed page 2 should be detent Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manny stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of centifi 29c. License number 30. Name and address of person Tock-ysville-md 2030 32. Registrar's Signature 31. Date filed (Month, Day, Year) -State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** 2007 June 17, 7:22PM ELIZABETH CELESTE FEENEY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 12, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Sex 1 M 2 XX **Funeral** Days 1926 Maryland 81 Director 216-20-6692 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21212 USA 712 Overbrook Road Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Me Ical Examiner ones. 1 ☐ Never Married XXMarried White 1 ☐ Yes XXNo Specify: Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Leo Hennegen Estelle Rethman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Husband 712 Overbrook Road Baltimore, Maryland 21212 Daniel N Feeney 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Maurial 2 Cremation 3 Removal from State 6/21/07 Parkwood Cemetery Baltimore, Maryland Donation 5 Other (Specify) Signature of Funeral 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, a comshock, or heart failure. List only years Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) þ Be Completed

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

9 □ Unknown	9LI ONKNOWN	
Part II. Other significant conditions	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
		24a. Was an autopsy performed performed to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical	26. Place of Death (C	Check only one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Specify) HOSpice
27. Manner of Death 1	28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? Injury M 1 Yes 2 No	f. Describe how injury occurred
3 Suicide 6 Could not 4 Homicide determine		Location (Street and Number or Rural Route Number, City or Town, State)
	Physician: To the best of my knowledge, death occurred at the time, date and place, an aminer: On the basis of examination and/or investigation, in my opinion, death occurred	

29d. Date signed (Month, Day, Year)

D25205 June 18, 2007

State

Registrar

6701 N. Charles St. Balto. Md 2120/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
JUN 2 0 2007

To the Hospital o within 24 hours af To the Funeral D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician 19,_ 2007 1:10 Α Marian Louise Fourney June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Center for Hospice Care Baltimore Towson Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 🕮 F 45 Jan. 11, 1962 Maryland 217-48-7709 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Scaggsville Maryland Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14. Race - American Indian 8714 Teresa Lane 20723 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 🔀 No Specify: Specify: 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Engineer Leach Wallace 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fred Pezzano Mary Catherine Heltzel 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Maryland 20723 Matthew Fourney Husband 8714 Teresa Lane; Scaggsville, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Department o Important: If any injury or once. Crest Lawn Mem. Garden 6/23/07 Marriottsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee 1630 Edmondson Avenue; Catonsville 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1cars ancrows **Physician** disease or condition resulting in death) /Medical Dus to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) attending physician for use as the buris Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has be irector, page 2 s 1□ Yes the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

Maryland 21215-0036

Baltimore,

Completed 25. Was case referred to medical examiner? Be funeral dire 2 I Director: After to d in by the funeral Certification: within 24 hours aft To the Funeral Di completely filled in

26. Place of Death Check onl on Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Nother (Specify) WUST WE 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No

27. Manner of D ath 1 D Natural 2 ☐ Accident 5 ☐ Pending investigation 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide determined

2 No

1 Tyes

29a. Certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) and title of certifier 29b. Signatur

29c. License number

29d. Date signed (Month, Day, Year)

N. Charles St Jowson up 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

State Registrar

20

Medical

this

death.

07-04567 Roge

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1	1.	941-14	1.0	**	w 1	0	
1	U	17			1	9	

er Lee Gear		State of Maryland / Department of Health and Mental Hy -For State Certificate of Death			
		Registrar	Reg. 2. Date of Death	No.	3. Time of Death
Physicia al Exami	-		June 15, 20	ay Year 07	0703 hrs
ai Exaiii		Roger Lee Gear, Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	00.10 10, 20	4c. County of Deat	h
		N/B I-95 at Mile Marker 606 Baltimore		N/A	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Birth(MM/DD/YYYY) 9. Bi	rthplace (State or
Director		Months Days Hours Min.	1	Forei	gn puntry) 24 2
Director	ļ	219-04-3551 1 XM 2 F 38 Yrs.	June 1.	2, 1969 ⁰	Duntry) Maryland
è		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location			10d. Inside City Limits
w any		Total Country			1 Yes 2 No
land f sho	ē	Pennsylvania York Shrewsbury	140-	. Citizen of What Cou	21
Mary 28a d at	Director	10e. Street and Number 10f. Zip Code	109	. Citizen of what co	and y?
the 3a or		124 North Main Street 17361		nited Stat	
ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 1874) 15. Was Decedent of Hispanic Origin? (Sp. 1874) 16. Was Decedent of Hispanic Origin? (Sp. 1874) 17. Marital Status		14. Race - Ame White, etc.	rican Indian, Black,
deatl or ite	ä	Never Married 2 X Married 1 Yes 2 X No		T.71-	
after	by f	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify: Wh:	
nours	pa	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retired)		6b. Kind of Business	rindustry
6 n 72	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	. 000	Chimmin.	_
withi iene.	mc	9 years Longshoreman-Foreman 17 Father's Name (First Middle Last) 18 Mother's Name	/Eirst Middle Ma	Shipping	-
15-1 filed I Hyg ad oth		77. Fation of Hallo (1 Hot, Hilland) 2007			
12 Id be fenta narke	Be c	Roger Lee Gear, Sr. Judith 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R	A. Dunca: Rural Route Numb	<u>N</u> er. Citv or Town, Sta	e, Zip Code)
D 2 shoul and N 7 is ir	То		*		
md 2 salth em 2 raun		Jody Gear (Wife) 124 North Main St. Sl 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	nrewsbur Date	v Pa 17: 20c. Location - City o	or Town, State
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland and Fleath and Maruell Hygiene. It: Titiene 71's in ansked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once.		1 57 Burial 2 Cremation 3 Removal from State crematory or other place)		_	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Manell Hygient Department of Health and Manell Hygient British I files and a state of ther than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once, injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other Specify: New Freedom Cemetery 6/2:	1/2007	New Freedo	om, Pa.
salt rmit. eparti iipor jury		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral 1	Homo of	Dundalk	Inc
	- "	26. Part I. Enter the diseas or complications that caused the death. Do not enter the mole or lying, such as a diac of	Pundalk.	Maryland	1 222 mate Interval
hysician		21a. Part I. Enter the diseas of complications that caused the death. Do not enter the more of rying, such as to rolad of failure. List only one cause on each line.	ir respiratory ares	I, Sir GR, TI MEDIL	Between Onset and Death
/Medical Examiner		Immediate Cause (Final disease a. Multiple Injuries			Death
		or condition resulting in death) Due to (or as a consequence of):			
	-E	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	nin	cause. Enter Underlying Cause (Disease or injury that initiated			
sit.	Examiner	events resulting in death) Last Due to (or as a consequence of):			
cecuted and transit	alE	d			
60, ate be exe hysician e burial -	Medical	UNPENDED			
760, icate be physicate burn	Ĭ,	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ancv	23d. Date of delive Month	ery Day Year
ox 6876(eath certificate attending phy for use as the b	sician/N	past 12 months? Live birth Pregnant at time of death Other (Specify)	andy	No.	22,
Box e death c the atten ed for us	ysic	1 Yes 2 No 9 Unknown g Unknown			
t the d	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?
ires that the signed by	l b		1 Yes	2 V No 3 P	obably 4 Unknown
Records, The law require ficate has been si	Completed		24a. Was a		autopsy findings available completion of cause of
law I has t	直		autops	ned? death	?
tal Rec cian: The l certificate l ector, page	5	25. Was case referred to medical 26.Place of Death (Check	1 Yes 2	No 1	Yes 2 No
Vital I ysician: his certifi director,	Be	examiner?		Residence 6 🗸 Ott	ner: Scene
of Vital ing Physician: After this certi tuneral director	2	1 Ves 2 No lospital linpatient 2 ER/Outpatient 3 DOA Nursir 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		ow injury occurred	101.000110
ding Ph.	on:	1 Natural 5 Pending Jun 15, 2007 0643 hrs 1 Yes 2 ✔ No		xed object collis	sion
Sior Attend death ector:	cati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S	treet and Number or	Rural Route Number, City
Division tal or Attendians after death.	ertification	Suicide Could not be determined (Specific) Major Board / Highway	or Town, St		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	ပိ	29a. Certifier A Continue Physician To the best of my knowledge, death occurred at the time, date and place, and			
the II nin 24 the Fu	edical	ore) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	at the time, date a	and place, and due to	the cause(s)
To To To Com	Med	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (I	
	_	highi mo O.C.M.E.		June 15, 2007	
6		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			
	State	Los Alverticians			
Regi		WING O COOK IN MARKED			

07-04655 Laura Jean Gladden

Me.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

2007 19799

			State			С	ertificate c	f Death			12 Dat	Reg. te of Death	No	3. T	ime of Death
hysicia		Regist 1. De	rar cedent's Name	(First, Middle,Las	st)						Mo		ay Year	1	1345 hrs
Examir	ner		Lai	ura Jea	n Glad	dden		4b. City, To		agation of C		le 10, 200	4c. County of	Death	
		4a. F	acility Name (if	f not institution, giv	e street and n	umber)				ocation of L	Jealii		Baltimore		1
		3	300 Edwar	ds Lane				Middle		2.1	- Io -		MM/DD/YYYY)		
			cial Security N		ex	7. Age (In y	rs. last birthday)	If Under		If Under 2					
Funeral		5. SU	14-17	6400			- 4	Months rs.	Days	Hours	Min. O	ct.26	,1972	Country	y) MD
Director					M 2X F										
		Usua	l Residence of			1100	City, Town or Loc	ation							d. Inside City Limits
any		10a.	State	10b. County		100.		ddle	Dit	70 °				1	Yes 2 X No
p wo g	_	l	MD	Balt	imore					V C I		100	. Citizen of Wh	at Country	?
ylan ton	ct.	10e.	Street and Nu	ımber				10f. Zip		_			USA		1
te Maryland or 28a-f show fied at once,	Director	3	58 Gr	ove Tho	orn Ro	ad			122						Indian Block
death with the Maryland or items 23a or 28a-f sho must be notified at once.	<u>a</u>					ecedent Ever	in U.S. 13.	Nas Deceder	nt of His	oanic Origir	n? (Specify	Yes or No-	14. Race White		ı Indian, Black,
h wit	uner	11.	Marital Status ✓ Never Marr	ied 2 Marrie	ed Armed	Forces?		f Yes, specif	Cuban	, Mexican, F	Puerto Nica	111, 010.7		Whi	+0
deat or its	ᇤ				1 Yes		No 1	Yes 2	X No	specify:			Specify:		
after al",	à	3	Widowed				ed) 16a, Dece	dent's Usual	Occupat	ion (Give ki	ind of work	done	16b. Kind of Bu	siness/Indi	ustry
atur	ē	15		ducation (Specify			durin	most of wor	king lite.	DO NOT u	ise retired)		own	home	2
72 h n "n at E	ete	E		condary (0-12)	College	e (1-4 or 5+)	Hom	emake	r						
5-0036 filed within 7. Hygiene. d other than	1 2	1	12t							18 Mother's	s Name (Fir	st, Middle, M	laiden Surname	±)	
d wi	Completed	17.	Father's Name	e (First, Middle, La	nst)	111			ŀ			Raibe			
Z15 be file ntal H rked o	B.		George	e V. Gl	adden_	111		III. Address	/Chra	at and Num	her or Rura	I Route Num	ber, City or Tov	vn, State, Z	Zip Code)
212 buld b Men marl	P	198	a. Informant's N	Name/Relationship	(Type, Print)		19b. Ma			Dri	Ve F	allst	on MD	2104	17
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiers it is a marked other than "natural", or items 23a or 28a-f sho trannantie event, the Medical Examiner must be notified at once, trannante event, the Medical Examiner	-		Mary A	A. Kure	k / Au	ınt						ate	20c. Location	- City or T	own, State
and 2		20	a Method of D	isposition			20b. Place of Di	sposition (Na or other place	me or ce	emetery,					
of H of H If it		1		Cremation		al from State	Garden	s of	Fai	th		2/07			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after de Department of Health and Mental Hygiene. Importanti: If item 27 is marked other than "natural", or important: If item 27 is marked other than "natural", or inity or other traumatic event, the Medical Examiner m		4	Donation	5 Other Spe	cify:			22. Name an	d Addres	s of Facility	300	Mace	Ave.	Balt	to, MD
ati mit. partr			11///	Funeral Service Li	/ /	0/1		Conne	11y	Fun	eral	Home	Ave of Es	ssex	21221
W 82 11	₹	1	Colli	r the disease of conly one cause of	anne		doath Do not er	ter the mode	of dying	, such as c	ardiac or re	espiratory air	est, shock, or h	eart	Approximate Interval Between Onset and
ysicia	n	23	Part I. Enter	r the disease, of c	omplications tr n each line.	lat dausee the	geath. Bo not o.								Death
/Medica		100	mediate Caus	se (Final disease	a Carbon	Mountaine	ITIONICATION								
Examine	er e	01	condition resu	ulting in death)	Due to (or	as a consequ	ience of):								
	H		equentially list	conditions.	b										
		e if	any leading to	n immediate	Due to (or	as a consequ	uence of):								
	•	E	Disease or inju	nderlying Cause iry that initiated	C. Due to (or	r as a consequ	uence of):								
2p. = -	t l	Examiner	vents resulting	in death) Last	Due to (or	do a comerq	,								ļ
760, cate be executed physician and	CCS				7	250									
'60, cate be execut physician and	rial	Medical	UNPEND	DED	AMENI								23d. Date	of deliver	у
60, ate b	he bu	활년	FEMALE:	lant research in th			of pregnancy	Fetal dea	th	3 Ector	oic pregnan	су	Month	n 1	Day Year
rtific	as th	E 23	3b. Was deced past 12 mo	lent pregnant in th inths?		Live birth Pregnant at ti	me of death 5	Other (S					i i		
× 6 th cer	r use	<u>:</u>		No 9 🗸 Uni		Unknown	5[Other (c	pconj						
Box 68760, e death certificate be the attending physic	of be	Physician	i res z	significant condit	(nowii g	ting to death	but not resulting	n the underly	ing caus	se given in	Part I.				the cause of death?
at the	tach		Part II. Other s	significant condit	ions continu	filling to death.	5					1 🔲 ነ	res 2 ✔ No	3 Pro	bably 4 Unknown
P.O. es that t	be de	읡										24a. Wa	as an 24	4b. Were a	utopsy findings availab
ds, equir	plnc	iğ.											topsy rformed?	prior to death?	completion of cause of
aw r	2 sh	Completed by											s 2 🗸 No	1 Y	res 2 No
Aec The I	page	팃							26.P	lace of Dea	th (Check o	only one)			
A. F.	ctor,	Be	25. Was case examiner?	referred to medica	Hospital:			tpatient 3	DOA	Other:		g Home 5	Residence	6 🗸 Oth	er: Scene
/its ysicis	direc		1 ✔ Yes	2 No	1	I IIIpadoi		ime of Injury		Injury at W	- 10	29d Deccri	be how injury or	ccurred	
S Ph	eral	1.	27. Manner of	Death	288	a. Date of Injui (Month, Day,Yo OUND:	ry 280. 1 ear) FOU		1	Yes 2		Subject e	xposed to	arbon m	nonoxide
D C	e fur	ē	1 Natura	0 1 01	iding I .	- 40 2007	1 1306	hrs				DOF Leaghin	on (Street and N	lumber or f	Rural Route Number, C
Division of Vital Records, tal or Attending Physician: The law requires after death.	by th	Certification:	2 🗸 Accide	٠	estigation 28	e. Place of In	jury - At home, fa	rm, street, fa	ctory, off	ice building	, etc.	- Tour	m Ctatal		
after after	d ii	ӭ	3 Suicio	det	ermined /9	Specify) Boa	at at marina						ards Lane , M		
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.	fille	Ö	4 Homi	cide				th occurred a	at the tim	ne, date and	d place, and	d due to the	cause(s) and m	anner as st	tated.
E Ho:	e Fu etely	g	(Check only		aminer:On the	e basis of exa	y knowledge, dea mination and/or ii	vestigation,	in my op	inion, death	h occurred	at the time, o			
ithin it	o the	Medical			and w	fanner stated.			29c. L	icense num	ber		29d. Date	e signed (Month, Day, Year)
F 3 F	– 5	ž	29b. Signatur	re and title of certi	ner //					D.C.M.E.			June 1	9, 2007	
				4 1/	//										
/	P		20 Name on	d address of pers	on who comple	ted cause of	death (Item 23a)					MD 0400	1		
00	ME			B. Ripple MD.	Deputy	Chief Medi	ical Examine			treet, Bal	itimore, I	MD 2120	·		
			O4 Data Sign			32 Registra	ar's Signature	Cosals	1						
		tate		MONTHA Sea	0 2007	Live	and side	1							
R	egi	strar	L			<i>a</i>									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Garhartt Frances Jun 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner tar Center that If Under 8. Date of Birth (Month, Day, Year) Aug. 16, 1920 Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Hours Months 1 □ M 2 🔀 New 052-20-0115 86 York Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lipury or other traumatic event, the Medical Examiner must he marking once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No **Funeral Director** Harford MD Edgewood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1007 Edgewood Road 21040 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🛂 No Specify: White Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Seward McIntyre Wava Victoria Cornish ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria Boughan 1007 Edgewood Road Edgewood MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Bayview Crematory 6/18/07 Baltimore MD 4 ☐ Donation , 5 ☐ Other (Specify) 21. Signatur Funer Service Licence 22. Name and Address of Facility 300 Mace Ave. Baltimore MD Home of Essex Connelly Funeral 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2helmer YIHV /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death 5 Other (specify) detached 9☐ Unknown 9 Unknow signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe within 24 hours after death. To the Funeral Director: After this certificate 1 TYes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be 2 No Other: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) P completely filled in by the funeral 27. Manner of D ath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

P.O. Box 68760, & Division or Vital Records, To the Hospital or Attending Physician:

State

Registrar

31. Date filed (Month, Day, Year) JUN 2 0

7004

29b. Signature and title of ertifier

2 NOV 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Bel Air Maryland

DHMH 17 Rev 1/2001

State Registrar Registrar's Signature

07-04587 Earl Gardner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ase	Type of Fillit in Black indensite inte	Ellowing and a least
	State of Maryland / Department of H	ealth and Mental Hygien
	Certificate of D	

	R	- For State legistrar					eruncate	01 1	Dealli		- 12	Date of De	Reg. No.		3. Time	of Death
Physicia	ın/	1. Decedent's Name										Month June 16,	Day	Year		35 hrs
al Examii		Earl	Gard			-11		1 41	b. City, Town, o	· Location o		JUNE 10.		County of Dea	ath	
	4	4a. Facility Name (i Johns Hopk						-	Baltimore	20000			1	N	/A	
	4			6. Sex			s. last birthda	v)	If Under 1 Yes	ar If Unde	er 24Hrs.	8. Date of I	Birth(MM/DI		Birthplace	(State or
Funeral		5. Social Security N	lumber			r. Age (iii yi	52		Months Day		_	12	23/1	OFIL For	eign Country)	MD
Director		44.64	UZ16	1 XM	2F		22	Yrs.				02	2711	10-1		
··· * * *		Usual Residence of 10a. State	Decedent 10b. County			10c. C	City, Town or I	ocatio	on						10 d. lr	nside City Limits
w any:			Nob. Society	$/\Delta$			Bal	tro	none					,	1 X	Yes 2 No
Maryland 28a-f show d at once	후	MD		171			0000		10f. Zip Code				10g. Citize	en of What C	ountry?	
Mary r 28a ed at	Director	10e. Street and Nu 5516	_	101	Ro	7 1			2	420			ļ	US	A	
th the			Buck			edent Ever i	nIIS 1	3 Was	s Decedent of H		•	cify Yes or	No- 1	14. Race - An		lian, Black,
th wirems	Funeral	Marital Status Never Marri	ed 2 M		Armed Fo	rces?	ì	If Ye	es, specify Cuba	n, Mexicar	, Puerto R	tican, etc.)		White, etc		
er dea	교	3 Widowed	-0	1	Yes es, Give Yaa	2 X N	lo	1	Yes 2 X N	o specify	:		5	Specify: 3	lack	
rs afte	ģ	15. Decedent's E		or	Dates:		d) 16a. De	cedent	t's Usual Occup	ation (Give	kind of wo	ork done	16b. Ki	ind of Busine		1
"nat	Completed	Elementary/Sec			College (1		dui	^	ost of working li		use retire	ea)		Hor		0.1
hin 7 e. than	g	1	grade		NI.	Ą		U	arpen	tev_	117		V	nprov	eme	>r 1+
5-0036 led within Hygiene. tother than	Ö	17. Father's Name	First, Middle	Last)						I	2 3	1 1	le, Maiden			
215 be file stal H rked c	Be	Walter	/ Ga	rdn	er_					10	dith) 170	oltor		tota Zin C	'ode)
2121 ould be fil d Mental I s marked lic event,	2	19a. Informant's N	ame/Relations		e, Print)	70			Address (Str	1.	Roa	d Route	20 H	M h		21206
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene teath and Mental Hygiene tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once		Kamor	77.	ran	er/	Nipe		516	Sition (Name of		Rou	Date L	20c. L	Location - Cit	y or Town,	
Imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene. Interficient 21 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dis		n 3	Removal fr	om State	cremator		her place)	cinclery,	101	1				
Pages ento		4 Donation	5 Other S	pecify:			Mt.Zi	ന_	<u>Cemet</u>	en	100	21 5		Baltin	Tore	1 Canton
Baltimore, permit. Pages I ar Department of He Important: If ite injury or other to		21. Signature of F	uneral Service	Licensee	· A			22. N	Name and Addre	ess of Facil	y Va	ughr	1.	~ ^ ^ 4	10 2	rad Soucs
D § S ≡ ii		23a. Part I. Enter	m (}	/		to the Do not	4	HOO YO	on such as	cardiac or	respirator	arrest, sho		App	proximate Interval
hysician		23a. Part I. Enter failure. List o	the disease, o nly one cause	e on each	line.										Ве	tween Onset and Death
/Medical Examiner		Immediate Cause						rrha	age compl	icated	by na	rcotic	intoxi	cation		
		or condition resul	ung in deauty	Du	e to (or as a	a consequer	nce or).									
	-e	Sequentially list of if any, leading to		Du-	e to (or as	a consequer	nce of):									
	nin	cause. Enter Und	derlying Cause	C.												
d sit	Examiner	events resulting i			ie to (or as	a conseque	nce ot):									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Function: After this certificate has been signed by the attending physician and an other statements Directors. After this certificate has been signed by the attending physician and appropriate the formal principle of the statement of the physician and appropriate the principle of the statement of the physician and appropriate the principle of the statement of the physician and appropriate the physician appropriate the physician app		TOUNDENDE		¬d	AMENDED											
760, Teate be exes physicians the burial -	n/Medical	XUNPENDE			#23a,2	.7 , 28a-f , outcome of	foregrancy	, go	368,6/27/	J/ 'TT'			23	3d. Date of de	livery	
8760, tificate be ng physic as the bur	Σ	IF FEMALE: 23b. Was decede	nt pregnant in		1 Live		2	F	etal death	3 Ecto	pic pregna	ancy		Month	Day	Year
certing conditions and conditions are a	sicia	past 12 mont			4 Preg	nant at time	of death 5		ther (Specify)				-			
Box 687. Bot death certific to the attending put the attending put hed for use as the	Phys	1 Yes 2	No 9 U		9 Unki					brown im	Dort I	23e	Did tobacco	use contribu	ite to the c	ause of death?
P.O. es that the igned by 1			nificant cond	litions c	ontributing	to death but	t not resulting	in the	underlying cau	se given in	rail i.					4 🗸 Unknown
i, P.C ires that signed												1000	Was an			y findings available
ords, v requir s been s should	ete												autopsy performed?	pri	or to comp ath?	letion of cause of
e law	11 5					-									/ Yes	2 No
tal Rection: The certificate	ြိ	OF Miss span ro	ferred to media	cal	Dr.	_	===		26.P	lace of Dea	ath (Check	only one)				
Division of Vital Records, tal or Attending Physician: The law requints after death. By Director: After this cartificate has been so it is bore than the mane of the control or are 2 should be the fine of the f	o Be	examiner?	2 No		spital: 1	Inpatient	2 ✔ ER/O	itpatie	nt 3 DOA	Other	Nursi	ng Home			Other:	
ing Phy After th		27 Manner of De			28a. Da	te of Injury hth, Day,Year)	28b. 7	ime o		Injury at W		28d. Des	cribe how in	njury occurred	t	
ion (tending eath.	ţ	1 Natural		ending	6/16	5/2007	un	k		Yes 2		unk				
isic Atte er des recto	ica	2 Accident 3 Suicide		vestigation ould not be	28e. Pl	ace of Injury	- At home, fa	rm, str	reet, factory, off	ice building	, etc.		tion (Street own, State)	and Number	or Rural F	Route Number, City
tal or	Certification:	3 Suicide Homicid	e de	termined	(Specif	1100						5570	Cedoni			pore, MD
Division Hospital or Attent 24 hours after death Funeral Director:			0 415 1	Physicia	n: To the b	est of my kr	nowledge, dea	th occ	curred at the tim	e, date and	place, an	d due to the	e cause(s) a	and manner a	is stated.	use(s)
Divisi To the Hospital or At within 24 hours after d To the Funeral Direct	Medical	one)	Medical E	xaminer:	On the basi	is of examina	ation and/or i	nvestig	gation, in my op	inion, deati	1 occurred	at the time	, date and p	Jiace, and do		
	3 S	29b. Signature a	and title of cert		0	0				cense num	ber			d. Date signe		Day, rear)
			11 Cm	10	whe.	W)				.C.M.E.				ıne 16, 20		
. 1		30. Name and a	ddress of pers	on who co	ompleted ca	ause of deat	th (Item 23a)					004				
0.		Laron Lo		Assista	ant Medi	cal Exam	iner 11	-	nn Street, B	altimore	, MD 21	201				
	Stat	e 31. Date filed (A	fonth, Day, Ye	7 200	17 32	Registrar's	Signature	600	enter							
	istra		ZMUL	0 200	11 000	Carlot Branch	- /	4								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** АМ **GOLDBERGER** JUNE 17 2007 5:05 MILDRED /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOWARD ELLICOTT CITY 3004 WEST RIDGE ROAD #216 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 08/26/1924 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 □ M 2 🙀 F Yrs. 82 WASHINGTON, D.C. Director 578-26-6912 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show adical Examiner must be notified at 1 ☐ Yes 2 X No PEMBROKE PINES Completed by Funeral Director BROWARD 10e. Street and Number 9400 N. HOLLYBROOK LAKE DRIVE BLDG. 6, #108 10f. Zip Code 10g. Citizen of What Country? U.S.A. 33025 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) than Elementary/Secondary (0-12) TEACHER EDUCATION permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important; If item 27 is marked other any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FIRTAG **ROSE** SAMEKOW 2 GABRIEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9400 N. HOLLYBROOK LAKE DRIVE BLDG 6, #108
PEMBROKE PINES, FL. 33025 19a. Informant's Name/Relationship (Type. Print) STANLEY GOLDBERGER / HUSBAND 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State BALTIMORE HEBREW CONG: 06/19/2007 BALTIMORE, MD 4 ☐ Donatjon 5 ☐ Other (Specify) 21. Signatur of Fungral Service Liver 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for each line. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death 23a. Part1 Immediate Cause (Final disease or condition resulting in death) **Physician** muth /Medical Due to (or # a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-trans Due to (or as a consequence of) physician Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed? Yes 2 No certificate 1∏ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

requires that the death certificate be executed Box 68760. P.O. Records, Division or Vital Physician; this After Hospital or Attending 24 hours after death.

Baltimore, Maryland 21215-0036

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

the

State Registrar

Medical

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701

Charles St. Balto. Mr. 2:20x

31. Date filed (Month, Day, Year) JUN 2 0

5 Pending investigation

6 Could not be determined

32. Redistrar's Signature Educa.

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death t's Name (First, Middle Physician 2:25 AM /Medical Name (If not institution Examiner timo re tvenue (In vrs. last birthday) **Funeral** Months 1 M 2 F 8L Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City Town or Location County 1 XYes 2 No Completed by Funeral Director timore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number venue Race - American Indian Black, White, etc. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: Blac Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life_DQ NOT use retired) hdary (0-12) College (1-4or 5+) umes 18. Mother's Name (First, Middle, Me Eather's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number of Parkville mD 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 07 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Po not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part1. Enter th shock, or heart e disease, or complications that caused the death. failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, $^{\mathcal{L}_{\mathcal{C}}}$ and Due to (or as a consequence of): attending physician for use as the hirial Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 4☐Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐Wo 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Ves 25 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 Yes 2€No 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 □Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day Year) filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide determined 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral C Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 1838 6/es denan 32. Registrar's Signature 31. Date filed (Month, Day,

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2007 Month **Physician** June 10, 2:00 AM M Andrew S. Harlow /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Dorchester 4329 Maiden Forest Road Vienna | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, May 3, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** West Virginia 1 ☑ M 2 ☐ F 85 Director 229-14-8107 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show 1 ☐ Yes 2 ▼ No Director MD Dorchester Vienna 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21869 4329 Maiden Forest Road Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 XXYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: white Š 3 ☐ Widowed 4 M Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16h Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) printer unk unk lithography permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe eny injury or other treumatic event, 9068. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Sheldon Harlow Mary Wiseman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Edwards/niece 4147 Ocean Gateway Vienna, MD 21869 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of European Service Licensee Wade, Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201

Approxima 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dronar /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physicien and dbe detached for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 Yes 2 ₽No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 1 Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0057040 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) AURORA ST. CAMBRIDGE

Registrar DHMH 17 Rev 1/2001

State

BRENDON

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

105

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death HORAK, Jr. 19,2007 June DIDSAM **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** 0970371925 Months Days Hours Mary land 1 X M 2 □ F Director 220-12-6131 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show Item 271s marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Menical Examiner must be notified at 1 □Yes 2 X No Director Dundalk MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code U.S.A. 21222 101 Center Place #616 Pages 1 and 2 should be filed within 72 hours after death vent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23s 12. Was Decedent Ever in U.S. Armed Forces? 1 A Yes 2 □ No If Yes, Give Year or Dates: 1942-44 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: altimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Drug Clerk Pharmacuetical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth M. Albert ဂ William A. Horak, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, MD 21214 2704 Gibbons Avenue. Albert Horak, Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Ite any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 06/22/2007 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Most Holy Redeemer 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee Ulgandria Bates 5305 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Preumonia Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ast IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 3 ☐Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year been signed by the should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 2 Accident Injury (Month, Day Year) 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: ompletely filled in by the f 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Registrar

31. Date filed (Month, Day, Year) State

JUN 2 0

29a. Certifier (Check only one)

29b. Signature and

ola A. Fashoyin, MD 4940 Eastern Nenue Baltimore MD Z1224 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

RES-000

29d. Date signed (Month, Day, Year)

June 19, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year 18TH 2007 Month **Physician** JUNE 2:48PM Vernon R. Hertsch /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE ST. AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Days Yrs. 79 10/11/1927 Director 213-26-4607 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show items 23a or 28a-f shor iner must be notifled at Director 1 ☐ Yes 2 No Maryland Baltimore Woodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2021 Englewood Avenue 21207 Funeral United States Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Austr if fleam 27 is marked other than "natural", or items 23, and other traumatic event, the Medical Examiner must ury or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumber 12 Contracting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Hertsch Irene Miller ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2021 Englewood Avenue Woodlawn, Maryland 21207 Ruby Hertsch / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once, 1 ☐ Burial 2 ☐ remation 3 ☐Removal from State Bayview Crematory 06/19/2007 | Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility David J. Weber Funeral Homes PA 21. Signature of Funeral Service 5311 Edmondson Ave. Baltimore, Maryland 21229 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SPONTANEOUS BACTERIAL PERITONITIS Physician disease or condition resulting in death) UNKNOWN /Medical Due to (or as a consequence of): **Examiner** UNKNOWN FAILURE CONGESTIVE HEART Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts. Due to (or as a consequence of): Examiner The law requires that the death certificate be executed VENTRICULAR ARRYTHMIA UNKNOWN that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the hurial by Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, DIABETES 1 Yes 2 No 3 Probably 4 Unknown Completed HYPERTENSION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has perform this certificate 1□ Yes 12☑No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death f □ Natural 2 □ Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred within 24 hours after deau..

To the Funeral Director: After 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P19924 MD 2007 JUNE 18

State Registrar

VERNOR

31. Date filed (Month, Day, Year)

JUN 2 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GIARIMA CHATURVEDI, 900, SOUTH CATON AVENUE, BALTIMORE, MD, 21229 32. Registrar's Signature 2007

Deserve

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** lunc 2007 /Medical 4c. County of Death City, Town, or Location of Deathy acility Name (If not instifution, give street and Examiner If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Funeral 1 □ M 2 KF 13-10-9056 land Director 10d. Inside City Limits 10a, State 10c. City, Town or Location 10b. County 28a-f ehow the Medical Examiner must be notified at 1 es 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married
3 Widowed 4 Divorced ☐Yes 2 No 1 ☐ Yes 2 No Specify: 31ac ۾ Year or Dates "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if item 27 ie marked other then." Elementary (Segondary (0-12) College (1-4or 5+) Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Procto 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: if Item 27 le eny injury or other trau 20a. Method of Disposition f⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) eral Services 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of or Attending Physician: The law requires thet the death certificate be executed the attending physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes this certificate 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification; To 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 1 Matural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident completely filled in by the within 24 hours after death To the Funers! Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide I 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier te filed (Month, Day, Year)

State

Registrar

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland & Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Olo **Physician** Jackson aran 4:00PM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Northbourne Road Baltimore If Under 1 Year If Under 24 Hrs. Year) 1944 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 194 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months Hours 1 ☐ M 2 💢 F 58 249.76.950 62 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County il Hygiene. . other than "natural", or flems 23a or 28a-1 ehov vent, the Medical Examiner must be motified at MD 1 Yes 2 □ No Baltimore Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21239 2010 Northbourne Road USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 KNo Specify: Black Specify: ģ 3 Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) General Electric Technician 12th grade permit. Pages 1 and 2 should be filed v Department of Heelih and Mental Hygie. Important: If Item 27 is marked other It any injury or other traumatic event, Itta 2006. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (E)st, Middle, Last) Willie Dixon Mompson 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2010 Northbourne Road Balto. MD 21239 Jackson 20b. Place of Disposition (Name of cemetery crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 06/20/07 Dwings Mills/MD 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Voughn C. Greene Funeral Srvcs 4905 York Road Battimore MD 21212 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYELOGENOUS CHRONIC Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner use as the burial-transit Due to (or as a consequence of): attending physicien for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) cete has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Dthar significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 2200 1 Yes 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No М investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

and

23a or 28a-f ehow

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) State Registrar



MA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0057450

JUNE, 19, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:10 a M 2007 June 8, KELLY WANDA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S CHEVERLY PRINCE GEORGE'S HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F Yrs. Aug. 16 1958 Wash., DC Director 48 579-86-5787 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Washington D.C. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö United States 238 20020 2015 37th St., S.E. #101 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic 12th Domestic 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if them 27 is marked other any liquy or other treumatic event 908. 17. Father's Name (First, Middle, Last) Be Shirley Kelly Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mt. Rainer, Md. 3407 Eastern Ave. Blair J. Duff / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Beltsville, Md. 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 6-21-07 21. Signa Ure of Funeral Service Licensee 22. Name and Address of Facility Capitol Mortuary, Inc. lly 1425 Maryland Ave., NE Wash., DC 23a. Part 1. Enter the disease, or complications that caused the death. Denot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10 YEARS ACQUIRED IMMUNODEFICIENCY SYNDROME /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, certificate has been signed by the attending physician irector, page 2 should be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2X No 2 Fetal death 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No 1 Yes Division of Vital Director: After this certific d in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1XXNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funarel Directo completely filled in by th 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide after 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death accurred at the Hospital 29a. Certifier Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D52298 June 13, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525 Greenway Center Dr. Greenbelt, Md. Divya Verma, M.D. P. Registrar's Signature 31. Date filed (Month, Day, Year)
JUN 2 0 2007

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 1:40P M 2007 June O. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 5571 Harpers Farm Road Columbia Howard 9. Birthplace (State or Foreign Country)
USSR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7 12.10.1907 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 🗆 M 99 220.31.0459 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a State 1 □Yes 2 No MD Howard Columbia Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 5571 Harpers Farm Road 21044 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No White 3 Widowed 4 □ Divorced Completed by 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Bookkeeper Government unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Khaim Kaplan Gerda Unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5571 Harpers Farm Rd. Columbia, MD 21044 Nella Kabakova/daughter 20h Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Columbia Memorial 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06.18.07 | Clarksville, MD Park 22. Name and Address of Facility Cremation And Funeral Balto 21. Signature of Funeral Service Licensee Alternatives 8717 Green Pastures Dr. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. MUMMENT AND DESIGNATION OF THE PROPERTY OF THE Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due t a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician hed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has perform ormed? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death. filled in by the 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours at To the Funeral L 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 30. Name and address of pe 31. Date filed (Month, Day, Year) State JUN 2

DHMH 17 Rev 1/2001

Registrar

0 2007

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #9, 22, perFH, 6868, 6/20/07 TT Certificate of Death

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** d00 /Medical or Location of Death lame (If not institution Examiner N/A altimore 9. Birthplace (State or Foreign ge (In vrs. last birthday) **Funeral** 1MM 2□F Months Director Deceden 10d. Inside City Limits 10a State Town or Location 10b. County 10c. City Show Examiner must be notified at 1 tres 2 No Director 28a-f 10e. Street and Number 10g. Citizen of What Country? 9 permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hyglene... Importants: If item 27 is marked other than "natural", or items 23a i any injury or other traumatic event, the Medical Examiner must b by Funeral Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 □ No 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 Married 1 □ Never Married Maryland 21215-0036 1 □ Yes 2EV No If Yes, Give Year or Dates: Specify 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) ondary (0-12) 2007 qe (1-4or 5+) 17. Father Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sui Be 2 19a. Informant's Name/Relationship (Type. Print) Baltimore, 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐Removal from State 4 Donation 5 Other (Specify) of Funera 21. Signatu Approximate Interval Between Onset and Death 23a. Part1. Enter the shock, or heart Immediate Cause (Final Physician nollas disease or condition resulting in death) LNS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed signed by the attending physician and deelached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.
To the Funeral Director: After this certificate has page 2 autopsy performe SUOTI 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOS PI Le 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No completely filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 50 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON MY 21204 8 6701 URS Cuenics ST N. 2 (Registrar's Signature 31. Date filed (Month State B. Bepter Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26_{AM} Month VW C **Physician** aundria Lewis 2007 */Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner mercy medical Center Baltimore Baltimore If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗗 F 217-84-2359 Months -1962 Director -19 MAR LAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits show items 23a or 28a-f sharer must be notified 1 Yes 2 No Baltimore Funeral Director mD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2749 21216 Winchester Street U.S. A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or item edical Examiner Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1☐Yes 2ĂNo Specify. Specify: Black þ 3 Widowed 4 Divorced Completed permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical. once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OUNSELOR URS BALTO BEHAVIOR & HEALTH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BOONE LMER VIOLA ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BORAH L MD. 212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 3-07 WOODLAWN, 4 ☐ Donation 5 ☐ Other (Specify) BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licenses BALTO. M.D. 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to initire rate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the lirector, page 2 s autopsy performed? Yes 2 No 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 2 1 Depatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 6 ☐Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 🗌 Yes 2 🗆 No 2 ☐ Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 1 x ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

Marvin J. 31. Date filed (Month, Day, Year) JUN 2 0 2007

29b. Signature and title of certifier

30. Name and address of per-

Idman wn 32. Registrar's Signature

n who completed cause of death (Item 23a) (Type, Print)

227 St. Pew

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Andreas A. Lohmann 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ June 7, 2007 1307 hrs Lohmann Andreas Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 908 St. Paul Street 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or tf Under 1 Year If Under 24Hrs. 6. Sex 7. Age (In vrs. last birthday 5. Social Security Number **Funeral** Hours Months Davs Country)Germany Director 591.85.9444 03-08-1975 32 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 1XX_{Yes 2} No Baltimore MD 28a-f shov notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 908 Saint Paul St. 21202 Germany Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes _{Specify:} White 4 X Divorced 1 Yes 2X No specify: permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. f Yes. Give Year <u>ک</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 unknown unknown 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown ANGELIKA Daum Lohmann Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print Angelika Lohmann/mother Zirudorfer Str 12, 90449 Nuruberg Germany 2 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition

1 Burial 2 Cremation 3 Baltimore, crematory or other place) Removal from State hesapeake Crematory 06-18-07 Beltsville, MD Donation 5 Other Specify: 22. Name and Address of Facility CAFA Signature of Funera Service Licensee 8717 Green Pastures Dr Towson MD 21286 at I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Medical Death Di henhydramine intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and executed Physician/Medical attending physician for use as the burial -X UNPENDED AMED BED 27,28a-f, perME, g868, 6/26/07 TT certificate be Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) The law requires that the death 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Records, P.O. ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? performed ✓ Yes 2 1 🗸 Yes No the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifi upletely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Other₄ Hospital: 1 DOA Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: Natural 1 Yes 2 X No Pending subject ingested diphenhydramine FND 6/7/2007 FND 1:01 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 X Suicide Could not be or Town, State) 908 St. Paul St. Baltimore, MD within 24 hours a

To the Funeral I (Specify) FND: residence 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 🗸 and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifie June 8, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Susan Hogan MD. 31. Date filed (Month) Day egistrar's Signatu

State

Registra

0 200 William .

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar 1. Decedent's Name (Fir	et Middle Las		f Mary		artment o		lealth and Death	Mental Hy	Reg. N	11	ţ .	2 Time of Death
107	Physici		Diana Merit		•						Month June		2007	Year	3. Time of Death 6:30 PM M
	/Medio		4a. Facility Name (If not a		street and num	nber)		4b. City, Tov		r Location of Deat Bethesda	h	4	tc. County of		v
	Funeral Director		5. Social Security Number 115-40-3351	41	x □ M 2 K F	7. Age (/n 5	yrs. last birthday, 8 Yrs.	If Under 1 Y	/ear ays	If Under 24 Hrs. Hours Min.	8. Date of Bi	irth ay, Yea	48	9. Birthp Cour	place (State or Foreign atry)
	pun 🛦		Usual Residence of Dece 10a. State 10b	edent . County		100	c. City, Town or L	ocation						- 14	Od Ingida City Limits
	Maryla f sho	o		ontgome	erv		Bethesda	ocation						'	0d. Inside City Limits 1 ☐ Yes 2 No
	the l	rect	10e. Street and Number					10f. Zip Co	ode		_	10g. C	Citizen of W	hat Cour	
	h with	alD	4808 Park A	ve				2081	6-			บร			,
5-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 3 □ Widowed 4 ✔		12. Was Dece Armed For 1 Yes If Yes, Giv Year or Da	rces? 2421 No	in U.S. 13.	Was Deceden If Yes, specify 1 ☐ Yes 2		ispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or N to Rican, etc.)	0-		, White,	
2-0	72 ho natur dical	eted	15. l (Specify or	Decedent's Edi	ucation de completed)		16a. Dece	dent's Usual C	ocup	ation	rkina		Kind of Bus		
121	within ene. than "	Completed	Elementary/Secondary		College (1	-4or 5+)				during most of woi i) ning Ana			ing	nist	ration on
nd 2	d d d	Be	17. Father's Name (First, William F I			<u>*</u>				18. Mother's Nan		e, Maide		?)	
Maryla	ges 1 and 2 should be filed v t of Health and Mental Hygie If Item 27 Is marked other t or other traumatic event, th	2	19a. Informant's Name/f	Relationship (T	,					and Number or Ru	ıral Route Numi	ber, City			
Baltimore, Maryland 2121	Pages 1 and 2 nent of Health int: If Item 27 iny or other tra		20a. Method of Disposition 1 ☐ Burial 24 ☐ Cre 4 ☐ Donation 5 ☐	emation 3 🗆		State	Ob. Place of Dispo cemetery, cre	matorý or othe	r plac		Jun 19 2007	!	Location - C	-	wn, State Maryland
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral	Service Licens		44.04		Name and A Rapp Fun		ss of Facility	ation Se er Sprin			v4 20	910-
	Physician /Medical Examiner		23a. Part1. Enter the dis shock, or heart faili Immediate Cause (Final disease or condition resulting in death)	ſ	a. Mali	aused the ach line. Lgnan			f dyin	_					Approximate Interval Between Onset and Death
8760, 6	death certificate be executed e attending physician and of for use as the bunal-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause End List with Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):												
O. Box 6	the death certifi y the attending ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	main	23c. If yes, outo 1 □ Live bi 4 □ Pregna 9 □ Unkno	irth 2 🗌 ant at time	Fetal death 3[⊒Ectopic pregr ☐ Other (specif					23d. Date Mont		ry Day Year
rds, P	law requires that the das been signed by the 2 should be detached	by	Part II. Other significant	conditions co	ntributing to de	ath but no	t resulting in the u	nderlying caus	e give	en in Part I.			use contrib		e cause of death?
Record	sician: The law rec certificate has bee irector, page 2 shou	Completed									24a. Was auto perfi 1 Yes		pri de	ior to cor eath?	psy findings available inpletion of cause of
VItal	ctor, p	BeC	25. Was case referred to examiner?	medical						26. Place of Dea			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	03	
-	h his	일	1 ☐ Yes 2 No				2 ER/Outpatie	nt 3□ DOA	Othe	er: 4 □ Nursing H	ome 5 2 Res	idence	6 □Other	(Specify	<i>'</i>)
0 00	nding Physician: th. :: After this certific s funeral director,		27. Manner of Death 1. Natural 5 □ 2 □ Accident	Pending Investigation	28a. Date of	of Injury h, Day Yea	28b. Time o Injury	f 28c.	Injun Work	yat ⟨? Yes 2 ∐ No	28d. Describe	how inj	ury occurred	d	
DIVISI	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Sertification:		Could not be determined		of injury - / ng, etc. (Sp	At home, farm, str pecify)	eet, factory, of			28f. Location (City or To	(Street a	and Number te)	or Rura	l Route Number,
	ne Hospit 24 hours ne Funera	edical C	29a. Certifier (Check only) 2 0	Certifying Phy Medical Exam	sician: To the Iner: On the ba	sis of exam	knowledge, deat	h occurred at the vestigation, in	he tin	ne, date and place pinion, death occu	e, and due to the arred at the time	cause((s) and man nd place, ar	ner as st	ated. the cause(s)
1	To the vithin To the comp	Me	29b. Signature and title of	of certifier	Why	(B)	. 14.0			number		29d. D	ate signed		

31. Date filed (Month, Day, Year) State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Genevieve Wroblewski 1355 Piccard Dr. Rockville, MD 20850 32. Restrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** JUNE 2007 11:50 A LEIBERT LIBBY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE NORTH OAKS HEALTH CENTER PIKESVILLE 8. Date of Birth (Month, Day, Year) 10/28/1914 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🙀 F MD 92 214-03-4556 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director BALTIMORE MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21208 APT.#207 725 MT. WILSON LANE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💥 No 11. Marital Status 1 □ Yes 2 🛱 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: WHITE Baltimore, Maryland 21215-0036 Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) EDUCATION TEACHER 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROSENTHAL MOLLY BENNETT MOSES ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2117 A PIERCE ST., SAN FRANCISCO, CA. 94115 MRS. CAROL A. COHN / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State SRAEL 06/19/2007 BALTIMORE, 22. Name and Address of Facility SOL LEVINSON & BRUS.; 4 ☐ Donation 5 ☐ Other (Specify) ISRAEL BNAI 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Matt Les 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 weeks Connective Physician /Medical ue to (or a 1 consequence of): Examiner Atheroschoope Se uentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ending physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 | Fetal death Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 2 No 1□ Yes Hospital or Attending Physician: the funeral director, 26. Place of Death (Check only one 25. Was case referred to medical examiner? Be Hospital Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death After 1 (Month, Day Year) Injury 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours all To the Funeral Completely filled in 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) Signature and title of certifier 29b MD 18, D38675

State Registrar PAUL

35

32. Fegistrar's Signatur

605

BALTIMORE

21202

N

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MESHULAM

Year)

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** HARVEY MCNEILL 05074 JUNY 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 0+ Bu Himore N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** UNK 237-42-6813 1 M 2 □ F 79 Months Days Hours 02/06/1928 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at MD N/A BALTIMORE CITY 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2095 ROCKROSE AVENUE 21211 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. 72 hours after 1

Never Married 2

Married 1 Yes No If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Completed by Specify BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withi nent of Health and Mental Hygiene. LABORER LABORER UNK and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNK UNK ပ Baltimore, Mary 19a. Informant's Name/Relationship (TOPOMMISSION ON 19b Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ARTIE SHAW / LEGAL GAURDIAN 10 N. CALVERT ST., STE 300, BALTIMO nt of Health a: If item 27 is N. CALVERT ST., STE 300, BALTIMORE, MD 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State CARMÉL CEM. Important: If any Injury or once, 6/20/07 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Funeral Service Licensee 4600 LIBERTY HEIGHTS AVE, BALTIMORE, . Inter the sease, or complications that caused the is ck, or hear ailure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Imme to Cause (Final disease or condition resulting in death) mas **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Ves 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To After this the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely and manner stated. within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D31464 MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. EVITAW ST Soute JOY HASITMI m 12 2/20) egistrar's Signature Year) State Registrar

JP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene | 1977

		_	- State Registrar		Ce	ertificate of		2. Date of De	Reg. No.	UU I	3. Time of Death				
Ph	ysicia	ın	Decedent's Name (First, Middle, La Richard Manahan	St)				June 1	2. Day	007	3:15 PM M				
	Medic kamin		4a. Facility Name (If not institution, given Harford Memorial			4b. City, Town, o	r Location of Death Havre de		4c. C	ounty of Death					
	neral			Sex 7. Ag	ge (In yrs. last birthday 66 Yrs.) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 06/11/	1941	9. Birthp Cour MD	place (State or Foreign ntry)				
pu &	Sis'		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or L	ocation					10d. Inside City Limits				
Maryla febo	le Del	ō	MD Harford	i	Bel Air						1 ☐ Yes 2 N				
r 28a	nati	rec	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Cou	ntry?				
th wit	ustbe	aiD	954 B Hillswood			21014			USA						
ZIZID-UUDO d within 72 hours after death with the Maryland giene. ar then "natural" or Iteme 23e or 28e-f ehow	other traumatic event, the Madical Examiner must be nutified at	by Funeral Director	11. Marital Status Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	<i>?</i>	. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 (No		pecify Yes or No Rican, etc.)		4. Race - Americ Black, White, Specify: Whit	etc.				
72 hg	dical	eted	15. Decedent's E (Specify only highest gr		16a. Dec (Giv	edent's Usual Occup e kind of work done DO NOT use retire	ation during most of work	king	16b. Kind N/A	d of Business/In	ndustry				
within	M al	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) .	bled	(d)		11,11						
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Innoctant: if Item 27 is marked other then	c event, II	To Be Co	17. Father's Name (First, Middle, Las. Unknown Unknown	")				r's Name (First, Middle, Maiden Sumame) a Unknown							
Maryland nd 2 should be file sith and Mental Hy 27 is marked oth	r traumat	-	19a. Informant's Name/Relationship Tania Byroade/Cou			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta P.O. Box 124 Fawn Grove, PA									
Saltimore, permit. Pages 1 a Department of Hea moortant: If Item	ry or othe					ematory or other pla		Jun 15 2007		ation - City or To sville,					
Dermit. Departm	any Inju		21. Signature of Funeral Service Licensee Chesapeake Crematory 2007 Beltsville, Mary 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryla												
Physi /Med Exam	dical niner	ner	23a. Part 1. Eiller the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	a. Respl Due to (or as	_	or respiratory a	rrest,		Approximate Interval Between Onset and Death						
requires that the death certificate be executed sear signed by the attending physicien and	the bu	The sequence of the sequence o													
the death certify the attending	be deteched for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	☐Ectopic pregnand ☐ Other (specify) _	у		23	3d. Date of deliv Month	rery Day Year				
quires that	old be dete	Ď	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cause g	ven in Part I.		obacco us Yes 2 □		the cause of death?				
He law	irector, page 2 should i	Completed						24a. Was auto perfo		24b. Were autoprior to codeath?	opsy lindings availab ompletion of cause of				
VIICAL reician: T	director, p	BeC	25. Was case referred to medical examiner?				26. Place of Dea								
OI VIIA Physician:	al dire	ို	1 □ Yes 2 No	Hospital:		BIIL 3 DOA		ome 5 ☐ Resi			ify)				
E 6 4	901	ton;	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inj (Month, D	ury 28b. Time ay Year) Injury	Wo	nyat ork?]Yes 2∐No	28d. Describe	now injury	occurred					
DIVISION I or Attending efter death. Director: Afte	in by the	Certification;	2 Accident Investigation 3 Suicide 6 Could not determined	28e. Place of Ir	njury - At home, larm, stc. (Specify)			281. Location (City or To	Street and wn, State)	Number or Rur	ral Route Number,				
To the Hospitel or Attendi within 24 hours efter death.	letely fillec	edical C			t of my knowledge, de of examination and/or stated.										
To th within	dElos	Me	29b. Signature and title of certifier				se number		29d. Date	signed (Month	. Dey, Year)				
			Kent The	DO			5222				2007				
	5		30. Name and address of person who	completed cause of	death (Item 23a) (Typ	e, Print) Her vre 1	de Gro	co M.	ک ک	2073					
	Sta	te	31. Date liled (Month, Day, Year)	321Regis	trar's Signature	9 19 .									

DHMH 17 Rev 1/2001

State Registrar

JUN 2 0 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician MINNIE 2007 MINKOVE JUNE 15 6:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JEWISH CONVALESCENT CENTER BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months RUSSIA 04/15/1909 212-09-1466 98 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show notified at 1 ☐ Yes 2☐ No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Item 27 Is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be 1840 REISTERSTOWN ROAD 21208 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify Completed by WHITE 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER GROCERY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill ment of Health and Mental Hant: If Item 27 Is marked oth jury or other traumatic even Be SIMON ROTHSTEIN FANNIE UNOBTAINABLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROYCE MINKOVE/DAUGHTER-IN-LAW 3743 ASHLEY WAY - OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of ANSAE MENTAL AND ANT PLACE) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 06/17/2007 BALTIMORÉ, MD Department of Important: If any Injury or once. 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses Matt Levinson 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** days /Medical Due to (or as a consequence of): **Examiner** months nscome re Esquestially list eorgilians, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one Other: 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the buriat-transit Division or Vital Records, P.O. Box 68760, To the Hospital c within 24 hours aff To the Funeral D

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

Medical

31. Date filed (Month, Day, Year) JUN 2 0 2007

29b. Signature and title of certifier

29a. Certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 W. BELVEDERE AVENUE, B 32 Registrar's Signature

and manner stated

MD

BALTIMORE

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0053928

29d. Date signed (Month, Day, Year)

BEGUM, MD MD - 2/2/5

15/07

07-04654 John E. Marsh

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 19820

		For State			Certi	ificate of	Death					eg. No.			75
Physician ledical Examine	/ 1 er	Decedent's Name (First, Middl John E. M	arsh								Date of Dea Month June 18,	Day 2007	Year	13	me of Death 345 hrs
	4	a. Facility Name (if not institution 3300 Edwards Lane	n, give street	and number)		4	b. City, To Middle		cation of	Death			ounty of De timore C		
Europal	5	. Social Security Number	6. Sex	7. Ag	e (In yrs. las	st birthday)	If Unde	r 1 Year	If Under	24Hrs.	8. Date of Bi	rth (MM/DD	/YYYY) 9.	Birthplac	e (State or
Funeral Director		213-86-2614	1 ^X M 2		4		Months	Days	Hours	Min.	June	18,1		eign Country)	MD
÷	-	Jsual Residence of Decedent 0a. State 10b. County			10c. City, T	Town or Location	on							10d.	Inside City Limits
vlaryland 28a-f show any d at once.			timor	e	В	altimo					i'				Yes 2 X No
21215-0036 Mental Hygiene marked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once.	Director	0e. Street and Number 103 Kent Wa	У		-		10f. Zip	21 2	22			10g. Citizer USA	n of What C	ountry?	
h with the ms 23a	ᇛᅥ	11. Marital Status		Vas Deceden			s Deceder es, specify				oify Yes or N can, etc.)	0- 14	Race - An White, etc		ndian, Black,
er deat			vorced If Yes,	. 00	X No	1	Yes 2	X No	specify:			Sp	ecify: Wh	nite	
urs aft tural"	ے⊢ ا≏	15. Decedent's Education (Spe	or Dat	es:	npleted)	16a. Deceden	t's Usual (Occupatio	n (Give ki	nd of wo	rk done	16b. Kin	d of Busine	ss/Indust	try
136 hin 72 hou le. than "na edical Exa	ompleted	Elementary/Secondary (0-12)	Co	ollege (1-4 or	5+)	self-				ise retiret		'	Trucl	c Dr	river
21215-0036 Juld be filed within 72 Mental Hygiene. marked other than 'e cevent, the Medical	ᇬ	17. Father's Name (First, Middle	e, Last)					18			irst, Middle	_	ırname)		
21215-0 21215-0 suld be filed w I Mental Hygic marked othe	8	Victor E. M				19b. Mailing					ra Do		or Tourn C	tato Zin	Code)
ID 21 should and Me and Me 27 is ma matic e	٩	19a. Informant's Name/Relation Barbara Mar			. ~	1.1					imro				oddo,
ore, MD es I and 2 sho of Health and If item 27 is		20a. Method of Disposition			20b. P	lace of Dispos	ition (Nan	ne of cem	etery,		Date	20c. Lo	cation - City	y or Towr	n, State
Baltimore, MD 2121 bernit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked njury or other traumatic event,	1	1 X Burial 2 Cremation 4 Donation 5 Other 8		moval from S	tate Ga [°]	rematory or oth rdens	of Of	Fait	h_	6/2	22/07	R	ossv:	ille	MD
Baltimo permit. Page Department of Important:	T	21. Son ture of Funeral Service			1100		Name and			200	Mac	e Av	e.Bai	lto.	MD 21221
	\dashv	23a. Part I. Enter the disease, o	r complication	ns that ause	d the death.									A	oproximate Interval etween Onset and
Physician Inclical	1184	failure. List only one caus Immediate Cause (Final diseas	e on each line	on Monox											Death
xaminer		or condition resulting in death)		(or as a con											
	<u>ē</u>	Sequentially list conditions, if any, leading to immediate		o (or as a con	sequence of	F):									
Δ.	Examiner	(Disease or injury that initiated events resulting in death) Last	C.	o (or as a con	sequence of	f):									
rand ecuted gra		events resulting in death) 2000	d												
e exe	/Medical	UNPENDED	AME	ENDED								1004	Data of do	i. com/	
3760 ificate ig phys s the b		IF FEMALE: 23b. Was decedent pregnant in		Live birth		nancy 2 Fe	etal death	3	Ectopic	pregnan	ю		Date of del Month	Day	Year
, P.O. Box 68760, res that the death certificate b signed by the attending physic be detactled for use as the bu	Physiciar	past 12 months?	nknown 9	Pregnant a	at time of de	-41-	ther (Spe								
O. Bc		Part II. Other significant cond	9		ath but not re	esulting in the	underlying	g cause g	iven in Pa	ırt I.	23e. Die	tobacco u	se contribu	te to the	cause of death?
P.C.	d b										1 🗆 `	res 2 ✓			y 4 Unknown
rds,	Completed											topsy	prio	r to comp	sy findings available pletion of cause of
eco he law ate has	E I											rformed? s 2 ✔ No	dea 1	Yes	2 No
al R	Bec	25. Was case referred to medi- examiner?							of Death Other					0.1	
'hysic r this c	P	1 ✔ Yes 2 No	Hospit	al: 1 Inpa	tient 2	ER/Outpatien			y at Work	?	Home 5 28d. Descril	oe how inju	ry occurred		
rding th.	ü	27. Manner of Death 1 Natural 5 Pe	ndina	FOUND: Day	(Year)	FOUND:	,,		res 2 🗸		Subject e	xposed t	o carbon	mono	xide
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detacted for use as	Certification:	3 Suicide 6 Co	ould not be		Injury - At h	1306 hrs ome, farm, stre	eet, factor	y, office b	uilding, et	tc.	28f. Locatio or Town 3300 Edwa	n (Street ar n, State) irds Lane	nd Number	or Rurai	Route Number, City
To the Hospital within 24 hours To the Funeral completely fille	al Cer	4 Homicide 29a. Certifier	Physician: T	(Specify) B	my knowled	lge death occu	urred at th	e time, da	ate and pla	ace, and	due to the c	ause(s) and	manner as	stated.	
Fo the vithin Somple	Medical	one) 2 Medical E	/ayid	he basis of e manner state	kamination a	and/or investiga			, death oo e number		t trie time, da		ce, and due Date signed		
	Σ	29b. Signature and title of cert	itier /				25	O.C.				- 1	9 19, 200	_	~ , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
lo SCHO		30. Name and address of pure	on who comp	leted cause of	f death (Iten	n 23a)	11 Penr	Street	Baltim	ore M	D 21201				
		Mary G. Rijople MD.		Chief Me	trar's Signat			- Sueet	, Dailin	iore, M	21201				
St Regist	ate	31. Date filed (Month, Day Yea	2007	Maria	. 1	642234	and the same								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	laryland / D	epartme Certifica	nt of H	lealth a		ental Hygi	iene	007	19821
	Dhusisi		1. Decedent's Name (First, Middle, Last)					1	2. Date of Death Month		Year	3. Time of Death
	Physicia /Medic	_	Clifford D. Mille					June 10, 2007			10:10 PMM		
7	Examin	er	4a. Facility Name (If not institution, give	street and number)	4b. Cit	, Town, or	r Location of				ounty of Death	
			3560 Allen Road 5. Social Security Number 6. Se	у 7 Д	ge (In yrs. last birti	nday) If Und	er 1 Year	Alle:		3. Date of Birth	W	Wicomico	
	Funeral Director			ÔM 2□F		rs. Month:		Hours	Min.	(Month, Day, Nov 15,	Year)	4 Mar	pplace (State or Foreign untry) yland
	P .		Usual Residence of Decedent									, , , , , ,	
	anylar show	_	10a. State 10b. County MD Wicomic		10c. City, Town								10d. Inside City Limits
	he M	Funeral Director	MD Wicomio		A	L1en	Sa Carla			14	On Citizon	of Mines Co.	1 Yes 2 No
	with e or	급	3560 Allen Road			101. 2	ip Code	0101	0	"	og. Citizei	n of What Cou	antry:
	ne 23	era	11. Marital Status	12. Was Deceden	t Ever in U.S.	13. Was Dec	edent of H	2181 Iispanic Orig		ify Yes or No- ican, etc.)	14.	USA Race - Amer	ican Indian,
38	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Medical Expolmer round be notified at	by Fun	1 Never Married 2X Married 3 Widowed 4 Divorced	Armed Forces 1 ☐ Yes 2 X If Yes, Give Year or Dates:	No	If Yes, sp		an, Mexican, Specify:	, Puerto R	ican, etc.)	Sį	Black, White	hite
Ģ	72 hor	Completed	15. Decedent's Edi (Specify only highest grad	ucation	16a.	Decedent's Us (Give kind of y	ual Occup	ation	of working	2	16b. Kind	of Business/l	ndustry
2	within 72 ene. than 'nai	npie	Elementary/Secondary (0-12)	College (1-4or		life. DO NOT	use retired	d)	OF WORKIN				
2	filed w Hygier other th	Co	17. Father's Name (First, Middle, Last)	0		farm	er	10 Mathe	da Nama	(First, Middle, N		ciculti	ıre
e, Marylan	ntal F	Be	Lester Miller								Maiden St	imame)	
	2 should be and Mental is marked aumatic ev	ပ္	19a. Informant's Name/Relationship (T	vpe. Print)	19b.	Mailing Addre	ss (Street			Yoder Route Number,	City or T	own. State. Z	ip Code)
	nd 2 selfth ar		Phyllis Miller/spo	•		560 A11					810	,	, , , , , , , , , , , , , , , , , , , ,
	Pages 1 a nent of Hee int: If item iry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify		20b. Place of		ame of	1	Da			tion - City or 1	Fown, State
Baltii	permit. Pages Department of Important: If it any injury or c		21 Signature of Fur eral Service Lio-ru	4	rector	State Balti	Anat	ss of Facility Omy Bo MD	oard 21201	655 W.	balt	imore	Street
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that cause	ed the death. Do n						est,		Approximate Interval Between
ă.	Physician		Immediate Cause (Final disease or condition	N/K	himes	Canda	Donas	do El	100				Onset and Death
į.	/Medical Examiner		resulting in death) Due to (or as a consequence of):									Tryuns.	
u		_	Sequentially list conditions, if any, leading to immediate		artin aisease					to you			
	per list	niner	of any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence	Ď							
	be executed sicien and burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or a	s a consequence o	f):	10.4						
760	ste be executed sysicien and he burial-transit	cal		d.									
89											-1	- 1	
.O. Box	The law requires thet the death certifica ate has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 ☐ Fetal death at time of death	3 ☐Ectopic 5 ☐ Other		/			23	d. Date of deli Month	very Day Year
<u> </u>	thet i	by Ph	Part II. Other significant conditions co	entributing to death	but not resulting in	the underlying	cause giv	en in Part I.		23e. Did tob	oacco use	contribute to	the cause of death?
ds	quires n sign								s 200	2 DNo 3 Probably 4 Unknown			
Records,	aw requires s been si 2 should b	piete			0					24a. Was a	n	24b. Were au	topsy findings available completion of cause of
	The I	Completed	et							autops perform	ned?	death?	2 No
E a	olan: artifica ctor. I	Bec	25. Was case referred to medical examiner?							Check only on	е		
<u>></u>	hysic this ce	은	1 ☐ Yes 2 ☐ ₩6	Hospital: 1 ☐ Inpa 28a. Date of In	tient 2 ER/Out		OOA Oth	ner: 4 ☐ Nui		e 5 Reside			cify)
Division of Vital	Attending Physician: r death. sctor: After this certifics by the funeral director, t	ation;	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	ime of njury M	Work?								
DIX:	tal or Att is after d at Direct ed in by t	Certification;	3 Suicide 6 Could not be 4 Homicide determined	rm, street, lact	reet, lactory, office 28I. Location (Street and Number or Rural F City or Town, State)				iral Route Number,				
	To the Hospital or Attending Physician: The lawinhin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	(Check only 2 Madical Examone)	ysician: To the besiner: On the basis and manner:	of examination and	Vor investigati	on, in my o	ppinion, deat	d place, a th occurre	d at the time, d	ate and p	lace, and due	to the cause(s)
)	To the within To the comple	Σ	29b. Signature and title of certifier	a. We	miels, h	v.D	9c. Licens	se number	384	2		signed (Monti	7, Day, Year)
			30. Name and address of person who (DIVISIO	11 ~	Type, Print)	ISB	ury	h	D 21	804		
	Sta		31. Date filed (Month, Day, Year)	32. Reg is	trar's Signature	1							
DH	Registi IMH 17 Rev 1/2		JUN 2 0 2	1007 July	yes St	60346							
	11 1104 1/2												

				Please	Type or Prin					-		gible.		
			For State		State of Ma	aryland /	-		Health and I	Mental Hy	E-m \	107	19822	
			Registrar	Registrar Certificate of Death						2. Date of De	Reg. No. 2. Date of Death 3. Time of Death			
	Physicia		Dorothy A. Merendino							June	Day 1 4	2007	3:00 PM	
	/Medic Examin	- 10			ve street and number)		4b. City, Town, or Location of Death			h		inty of Death		
			Franklin	1 Squar		a Ce	nter	If Under 1 Yea	osedale				NDTP place (State or Foreign	
	uneral		5. Social Security N		Sex 1 17. Ag 1 1 M 2 1 F	77 Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.			8. Date of Bir (Month, Di 11/09/	1929	Cou	rvland		
	They will the Madical Examinat must be notified at the many and the most series of the mo		Usual Residence of Decedent							1.17007				
arylan		_	10a. State	10b. County		10c. City, Town or Location							10d. Inside City Limits 1 ☐ Yes 2 X No	
he M		Director	MD 10e. Street and Nu	Harfor	rd	Fall	ston	10f. Zip Code			10a. Citizen	of What Cou		
with	23a or			rent Road	1			2104	17		U.S		,	
death	me 23	Funeral	11. Marital Status	Leite Road	12. Was Decedent Armed Forces?		13. V		Hispanic Origin? (S ban, Mexican, Puer	pecify Yes or No		Race - Ameri Black, White		
after	or items		_	ried 2 Married	1 Yes 2 X			i Pes, specily Co		0 (110011, 010.)		ecify:		
hours	'natural', adical Exe	d by	3 X Widowed	4 ☐ Divorced	Year or Dates:	1.6	Sa Dacad	lent's Usual Occ	unation		16b Kind (White Business/Ir		
in 72	dedic	Completed		(Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+			(Give kind of work done during most of working life. DO NOT use retired)				,			
d with	snould be and Mental marked o	mo	Elementary/Secondary (0-12)			Hostess					Resta	Business		
9 1		Be	The state of the s								(First, Middle, Maiden Sumame)			
y o		ပ္	Bernard	-	(T D)		Ob. Maille	Address (Class			szynska ner, City or Town, State, Zip Code)			
d 2 st			19a. Informant's N		(sister)				Court - I				21220	
s 1 and	Item (20a. Method of Dis	•		ceme	of Dispos	sition (Name of natory or other p		Date		on - City or T		
Pages	nent o int: If iry or			☐ Cremation 3 5 ☐ Other (Spec	□Removal from State ify)	1		-	Gdns. 06/	18/2007	Baltin	nore, I	Mryland	
permit.	Depertment of Health a Importent: If Item 27 is any injury or other tre		21. Signature of Fi	uneral Service Lic	ensee	/							Home, P.A.	
u a	25 # 9		On Prote Salar	J! /	mplications that cause	d the death. D			lair Road			Maryl	and 21087 Approximate	
				art failure. List on	y one cause on each li		- C	C .	ying, such as cardia	c or respiratory	arrost,		Interval Between Onset and Death	
	ysician Aedical		disease or condition resulting in death) Due to (or as a consequence of):											
Ex	xaminer		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)											
g		Iner												
xecute	and I-trans	Examiner	that initiated event resulting in death)	s	c	a consequent	ce of):							
D P P	sician buria			•	d.									
The law requires that the death certificate be executed	been signed by the attending physician and should be detached for use es the burial-transit	Physician/Medical	15.55111.5		<u> </u>									
Se dia	ttendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1						2			very Day Year		
De de	the at	ysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify)											
, L.	ed by	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did	e. Did tobacco use contribute to the cause of death?				
v requires	n sign ald blu								1 🖻	1 Yes 2 No 3 Probably 4 Unknown				
S S S	2 8	Completed	244						aut	. Was an autopsy findings available prior to completion of cause of				
£ £	s certificete hes b lirector, page 2 s	Com								per 1 ☐ Yes	formed? 2 No	death? 1 ☐ Yes	2□ No	
VILCE sicien:	certifi	Be	25. Was case refe examiner?	1	Hospital:				Othor	ath (Check only				
2 ਵੂ	ar this aral di	5 To	1 Yes 2		1 Mnpati 28a. Date of Inj (Month, Da		Outpatier b. Time of	IL SEL DOA	DA Oster: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred			ery)		
nd ing	ath. r: Afte e func	atlor	1 ⊠Natural 2 ☐ Accident	5 Pending investigat		y Year) Injury Work? M 1 ☐ Yes 2 ☐ No								
UNISION i or Attending	fler dea	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju building, etc								(Street and Number or Rural Route Number, wn, State)			
Hospitai	within 24 hours after death. To the Funerel Director: After this certificete he completely filled in by the funeral director, page	edicai C	29a. Certifier (Check only one)		Physician: To the best aminar: On the basis	of examination								
o the	within 2 To the complex	Med	one) and manner stated. 29b. Signature and tipe of certifier					29c. Lice	ense number	29d. Date s	9d. Date signed (Month, Day, Year)			
-			1	w		VASIUA	003	I	D0064756, 6/14/2007.				· - -	
	12		30. Name and add	dress of person wh	o completed cause of	doath (Item 22	a) /Type	Print)	vare Driv	e Ball	imare	mn.	21237	
		ate	31. Date filed (Mo	onth, Day, Year)	32. 39js	trar's Signature	Y (III)	neals !	AIC VIIV	17411	THOLE	- (117)	n.v.	
	riegist	Juli		JUN 2 0	7007 EVes	126 134	150	No. of London						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2007 **Physician** 16, 12:38 PM June George Alexander Martin, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Frederick Northampton Manor Nursing Home Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Days Hours 1 X M 2 □ F 83 Dec. 19, 1923 Rhode Island 578-24-4817 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1XXYes 2□No Director Maryland Frederick Frederick 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? United States 810 Stratford Way, Unit B 21701 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 KXYes 2 □ No WW2 If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☑ No White à Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Legal Administrator Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George A. Martin, Sr. Gladys Beall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 810 Stratford Way, Unit B Frederick, MD 21701 Rose Marie Martin / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Memorial Gardens 20a. Method of Disposition June 23, 20c. Location - City or Town, State 1 ABurial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 2007 Frederick, Maryland 21. Signatute Fur eral Service Licensee Restnaven Fulferal Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) erepto vasenlar Days Due to (or as a consequence of): nextension Sequentially list conditions, it by a ling to import the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an 1∐ Yes 25. Was case referred to medical examiner? Be 26, Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient Other: ٩ 2 ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

be executed P.O. Box 68760.

burial-tran nding physician use as the buria signed by the attending a Division or Vital Records, page 2 s funeral director this After To the Hospital or Attendil within 24 hours after death.

To the Funeral Director; A completely filled in by the fu

Funeral

Director

r 28a-f show notified at

ò be

permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or items 23a any Injury or other traumatic event, the Medical Examiner must I

Physician

/Medical

Examiner

3altimore, Maryland 21215-0036

State Registrar

Daced 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier (Check only one)

> MM Zaidi

manner stated.

Tou House Ave, Frederick MD

043091

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

32. Registrar's Signature

ysicia		For State Registrar		Ce	ertificate of De	eath	Re	g. No.	1 10
		Decedent's Name (First, Middle, L		2. Date of Death Month	Day Ye	3. Time of D			
Medica	al .	KICHARD L. 4a. Facility Name (If not institution, a	M/X	r)	4b. City, Town, or Lo		JUNE	14 200 4c. County of D	
camine	31	, ,	COLUM			HOWA			
neral				ge (In yrs. last birthday) If Under 1 Year II	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9	Birthplace (State or I
ctor		216-36-3604	1 ½ tM 2□F	67 Yrs.	Line Days		Sept. 25		Maryland
	- 1	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City
lied a	ţō	Maryland How	ard		Ellicott Ci	itr			1 □Yes 2
a noti	- A	10e. Street and Number	ard		10f. Zip Code	LLY	10	g. Citizen of What	Country?
ust b		3631 St. Jo	ohns Lane		21	042		USA	
or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 ∑ If Yes, Give Year or Dates	No	. Was Decedent of Hispa If Yes, specify Cuban, 1 ☐ Yes 2☑ No S	anic Origin? (Spe Mexican, Puerto f Specify:	cify Yes or No- Rican, etc.)		American Indian, Vhite, etc. White
calE	ted	15. Decedent's	Education	16a. Dece	edent's Usual Occupation	on		 16b. Kind of Busine	ess/Industry
Men	Completed	(Specify only highest g	rade completed) College (1-4o	(Give	e kind of work done duri DO NOT use retired)	ing most of workir	ng		
an '	Sol		3	C	ivil Engine				neering
even	Ba	17. Father's Name (First, Middle, Las			18	8. Mother's Name		,	
Tall I	၉	Vernon I 19a. Informant's Name/Relationship		10h Mai	ling Address (Street and		erine L.		to Tin Code)
trau		Inez L. Mix	- Wife	T T	1 St. Johns				
other	H	20a. Method of Disposition			osition (Name of ematory or other place)			20c. Location - City	
		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Metro Cr		6-18-	-2007 C	atonsvil	le, Maryla
once.	Ì	21. Signature Funeral Service Lic	-		22. Name and Address of Funeral Hom	of Facility Ster			
E 6		(Chre	Kell	2	1630 Edmond	ie of Cat Ison Aver	nue; Cat	e, inc. onsville	, MD 21228
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	inplications that cause ly one cause on each	ed the death. Do not en line.	nter the mode of dying,	such as cardiac o	r respiratory arre	est,	Approximate Interval Between
an		Immediate Cause (Final disease or condition	. SEPT	IC SHOCK	K				Onset and De
cal ner		resulting in death)	Due to (or a	s a consequence of):					
Star of	<u>-</u>	Sequentially list conditions,		IL PERIT	DNITIS				HOURS
2	Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events	PERF	PRATED S	SIGMOID	DIVERT	7160611	75	
rial-tr		resulting in death) Last		s a consequence of):		<u> </u>		-	
the burial-transit	dical		d						
as 1	Med			o of programs					
0		IF FEMALE:	00- 16						
000	/sician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		2 Fetal death 3 at time of death 5	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Ye
detached for use	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1⊡Live birth 4⊡Pregnant 9⊡Unknown	2 ☐ Fetal death 3 at time of death 5	Other (specify)	in Part I.	23e. Did tob	Month	,
pe detached	ρ	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □Live birth 4 □ Pregnant 9 □ Unknown s contributing to death	2 Fetal death 3 at time of death 5 but not resulting in the	Other (specify)	in Part I.	23e. Did tob	Month acco use contribut	Day Ye
	ρ	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions	1 □Live birth 4 □ Pregnant 9 □ Unknown s contributing to death	2 Fetal death 3 at time of death 5 but not resulting in the	Other (specify)	in Part I.		Month acco use contribut s 2♥No 3□	Day Ye te to the cause of dea Probably 4 □Un
	ρ	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions	1 □Live birth 4 □ Pregnant 9 □ Unknown s contributing to death	2 Fetal death 3 at time of death 5 but not resulting in the	Other (specify)	in Part I.	1 ☐ Ye	Month acco use contribut s 22 No 3	Day Ye te to the cause of dea Probably 4 Uni e autopsy findings av to completion of cau
	Completed by	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions ACUTE RENA	1 □Live birth 4 □ Pregnant 9 □ Unknown s contributing to death	2 Fetal death 3 at time of death 5 but not resulting in the	Other (specify)	in Part I.	1 Ye 24a. Was ar autops perform 1 Yes 2	Month acco use contribut s 2 No 3 24b. Wer prior deat	Day Ye te to the cause of dea Probably 4 Uni e autopsy findings av to completion of cau
	Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions	1 □Live birth 4 □ Pregnant 9 □ Unknown s contributing to death	2 Fetal death 3 at time of death 5 but not resulting in the	Other (specify)underlying cause given i	6. Place of Death	1 Ye 24a. Was ar autops perforn 1 Yes 2	Month acco use contribut s 2 No 3 24b. Wer prior deat	Day Ye te to the cause of dea ☐ Probably 4 ☐ Uni e autopsy findings av to completion of cau h? Yes 2 ☐ No
	To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	1 Live birth 4 Pregnant 9 Unknown contributing to death	2 Fetal death 3 at time of death 5 but not resulting in the LE	□ Other (specify) □ underlying cause given i underlying cause given i 20 ent 3□ DOA Other: of 28c. Injury at	6. Place of Death	1 Ye 24a. Was ar autops perforn 1 Yes 2 (Check only one	Month acco use contribut s 2 No 3 C yed? deat 1 C	Day Ye te to the cause of dea ☐ Probably 4 ☐ Uni e autopsy findings av to completion of cau h? Yes 2 ☐ No
	To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	Hospital: 1 Prepared to death (Month, Control on the last of the l	2 Fetal death 3 at time of death 5 but not resulting in the LE	underlying cause given i	16. Place of Death 4 □ Nursing Hor t 2 s 2 □ No	1 Ye 24a. Was ar autops: perform 1 Yes 2 (Check only one) me 5 Reside	Month acco use contribut s 2 No 3 24b. Werr y deat 1 1 32b. acco use contribut s 2 No 3 4cco use contribut s 2 No 3 4cco use contribut acco use contribut s 2 No 3 4cco use contribut s 3 No 3 4cco use contribut s 3 No 3 4cco use contribut s 3 No 3 4cco use contribut s 3 No 3 4cco use contribut s 4 No 3 4cco use contribut s 4 No 3 4cco use contribut s 4 No 3 4cco use contribut s 4 No 3 4cco use contribut s 4 No 3 4cco use contribut s 4 No 3 4cco use contribut s 4 No 3 4cco use contribut s 4 No 3 4cco use contribut s 4 No 3 4cco use contribut s 4 No 3 4cco use contribut s 4 No 3 4cco use contribut s 4 No 3 4cco use contribut s 4 No 3 4cco use contribut s 4 No 3 4cco use contribut s 4 No 3 4cco use contribut s 4 No 3 4cco use contribut s 4 No 3 4cco use contribut s 4 No 3 4cco use contribut s 4 No 3 4cco use contribut s 5 No 3 4cco use contribut s 6 No 3 4cco use contribut s 6 No 3 4cco use contribut s 7 No 3 4cco use contribut s 7 No 3 4cco use contribut s 7 No 3 4cco use contribut s 7 No 3 4cco use contribut s 7 No 3 4cco use contribut s 7 No 3 4cco use contribut s 7 No 3 4cco use contribut s 7 No 3 4cco use contribut s 7	Day Ye te to the cause of dea □ Probably 4 □Uni e autopsy findings avitocompletion of cautory h? Yes 2 □ No Specify)
	To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions ACUTE RENA 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Month, £ on be 28e. Place of in 28e.	2 Fetal death 3 at time of death 5 but not resulting in the LE	underlying cause given i	16. Place of Death 4 □ Nursing Hor t 2 s 2 □ No	1 Ye 24a. Was ar autops: perform 1 Yes 2 (Check only one) me 5 Reside	Month acco use contribut s 2 No 3 24b. Werr prior deat 1 1 2) nce 6 Other (3) w injury occurred	Day Ye te to the cause of dea ☐ Probably 4 ☐ Uni e autopsy findings av to completion of cau h? Yes 2 ☐ No
	Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	Hospital: 1 pripa 28a. Date of In (Month, Don be done) 28e. Place of In building, Physician: To the besaminer: On the basis	2 Fetal death 3 at time of death 5 but not resulting in the state of the state of the state of examination and/or interest at the state of examination and/or interest at the state of examination and/or interest.	underlying cause given in the street, factory, office at hoccurred at the time,	d6. Place of Death 4 □ Nursing Hor t 2 s 2 □ No 2 date and place, a	24a. Was ar autops: perform 1 yes 2 a (Check only one 28d. Describe house 28d. Describe house 28d. Location (Str. City or Town and due to the ca	Month acco use contribut s 2 No 3 24b. Wer prior deat 1 29) nce 6 Other (3 w injury occurred reet and Number o , State)	Day Ye te to the cause of dea Probably 4 Uni e autopsy findings av to completion of cau h? Yes 2 No Specify) r Rural Route Number
	edical Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	Hospital: 28a. Date of In (Month, Don) be d 28e. Place of in building,	2 Fetal death 3 at time of death 5 but not resulting in the state of the state of the state of examination and/or interest at the state of examination and/or interest at the state of examination and/or interest.	underlying cause given in the street, factory, office ath occurred at the time, investigation, in my opinion.	66. Place of Death 4 Nursing Hor t s 2 No 2 date and place, a nion, death occurre	1 ☐ Ye 24a. Was ar autops: perform 1☐ Yes 2 (Check only one me 5 ☐ Reside 28d. Describe ho 28f. Location (Str. City or Town and due to the caed at the time, di	Month acco use contribut s 2 No 3 24b. Wern prior deat 1 1 29) nce 6 Other (3 w injury occurred reet and Number o , State) ause(s) and manne ate and place, and	Day Ye te to the cause of dea Probably 4 Uni e autopsy findings averto completion of cause h? Yes 2 No Specify) Framal Route Number or as stated, due to the cause(s)
	Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	Hospital: 1 pripa 28a. Date of In (Month, Don be done) 28e. Place of In building, Physician: To the besaminer: On the basis	2 Fetal death 3 at time of death 5 but not resulting in the state of the state of the state of examination and/or interest at the state of examination and/or interest at the state of examination and/or interest.	underlying cause given in the time, investigation, in my opin	6. Place of Death 4 Nursing Hor t 2 s 2 No 2 , date and place, a nion, death occurre	24a. Was ar autops: perform 1 Yes 2 a (Check only one 28d. Describe house 28d. Describe house 28f. Location (Str. City or Town and due to the cared at the time, di	Month acco use contribut s 2 No 3 24b. Werr prior deat 1 29) nce 6 Other (3 w injury occurred ause(s) and manne ate and place, and add. Date signed (M	Day Ye te to the cause of dea Probably 4 Uni e autopsy findings av to completion of cau h? Yes 2 No Specify) or Rural Route Number or as stated, due to the cause(s)
	edical Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	Hospital: 1 Manage 28a. Date of In (Month, Donate of In (Month, Donate of In (Month)) Physician: To the besaminer: On the basis and manner:	2 Fetal death 3 at time of death 5 but not resulting in the state	underlying cause given in the street, factory, office ath occurred at the time, investigation, in my opin 29c. License in the street investigation, in my opin 29c. License in the street investigation.	6. Place of Death 4 Nursing Horit t 2 s 2 No 2 date and place, anion, death occurrence.	1 ☐ Ye 24a. Was ar autops performed to the care at the time, do	Month acco use contribut s 2 No 3 Contribut s 3 No 3 Contribut s 2 No	Day Ye te to the cause of dea Probably 4 Uni e autopsy findings average to completion of cauth? Yes 2 No Specify) or Rural Route Number as stated, due to the cause(s) fonth, Day, Year)
completely filled in by the funeral director, page 2 should be detached	edical Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions ACUTE RENA 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending investigati 3 Suicide 6 Could not 4 Homicide 1 Certifying I 29a. Certifier (Check only one) 2 Medical Ex	Hospital: 1 Manage 28a. Date of In (Month, Donate of In (Month, Donate of In (Month)) Physician: To the besaminer: On the basis and manner:	2 Fetal death 3 at time of death 5 but not resulting in the state	underlying cause given in the street, factory, office ath occurred at the time, investigation, in my opin 29c. License in the street investigation, in my opin 29c. License in the street investigation.	6. Place of Death 4 Nursing Horit t 2 s 2 No 2 date and place, anion, death occurrence.	1 ☐ Ye 24a. Was ar autops performed to the care at the time, do	Month acco use contribut s 2 No 3 Contribut s 3 No 3 Contribut s 2 No	Day Ye te to the cause of dea Probably 4 Uni e autopsy findings average to completion of cauth? Yes 2 No Specify) or Rural Route Number as stated, due to the cause(s) fonth, Day, Year)
pletely filled in by the funeral director, page 2 should be o	Medical Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	Hospital: 1 Manage 28a. Date of In (Month, Donate of In (Month, Donate of In (Month)) Physician: To the besaminer: On the basis and manner:	2 Fetal death 3 at time of death 5 but not resulting in the state of the state of the state of examination and/or istated.	underlying cause given in the street, factory, office ath occurred at the time, investigation, in my opin 29c. License in the street investigation, in my opin 29c. License in the street investigation.	6. Place of Death 4 Nursing Horit t 2 s 2 No 2 date and place, anion, death occurrence.	1 ☐ Ye 24a. Was ar autops performed to the care at the time, do	Month acco use contribut s 2 No 3 Contribut s 3 No 3 Contribut s 2 No	Day Ye te to the cause of dea Probably 4 Uni e autopsy findings average to completion of cauth? Yes 2 No Specify) or Rural Route Number as stated, due to the cause(s) fonth, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 30 AM. ZUDI NAOMA MILLER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 01/09/1916 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 🗌 M 91 MD Director 213-14-8327 Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director **BALTIMORE** MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ed other than "natural", or items 23a or event, the Medical Examiner must be 31 STONEHENGE CIRCLE APT. 4 21208 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No WHITE 2 Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than 'any injury or other traumatic event, the Meones Elementary/Secondary (0-12) College (1-4or 5+) BUYER WHOLESALE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SOL Ι HYMAN HANNAH SCHUMAN Pages 1 and 2 should 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HELENE MILLER / DAUGHTER 11 JOANNA COURT - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) BETH TFILOH CONG. 06/19/2007 WOODLAWN, MD 21. Signal ore of Funeral Service Ulcen 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pah). Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest strock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm ate Cause (Final disease or condition resulting in death) **Physician** 24 HRS NECTOTIC & ISCHEMIC /Medical Due to (or as a consequence of): Examiner YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ATHEROSCLE ROSI Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buna Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2□ No 3 У robably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1□ Yes or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient P 2 ER/Outpatient 3 DOA 27. Manner of D Date of Injury (Month, Day Year) 28a 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral C To the Hospitai 29a, Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

2007

State Registrar 30. Name and add

unolan

31. Date filed (Month, Day, Year)

h who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

301 HOSP 1728

ORIGINAL

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year NEWTON 1715 BURGESS JUNE 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death RANDALLS TO WN NORTHWEST BALTIMORE HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. 09-27-Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 231-32-1211 1**▼**M 2□ F 76 Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MY Baltimore 1 X Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Blac 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic 67th 17. Father's Name (First, Middle, Last). New Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State .olzoot Baltimure, MD 21. Signatur of Funeral Service Licensee Baltimore Nat'l P. Ke, Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) hon-Small cell metastatic Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2▼No autopsy performed 1☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year)

/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760, physician attending pl for use as t director, within 24 hours after death

To the Funeral Director:
completely filled in by the

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ō must be

23a

7 Is marked other than "natural", or Items traumatic event, the Medical Examiner mu

Department of Health a Important: If Item 27 Is any Injury or other trainonce.

Physician

nd Mental Hygiene. marked other than

Pages 1 and 2 should be filed within 72 hours after death

altimore, Maryland 21215-0036

notified

Funeral Director

Completed by

Be

2

Examiner Physician/Medical 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Ď Be Completed 25. Was case referred to medical examiner? 1 Yes 2 No Medical Certification: To 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3☐ Suicide determined 4 Homicide 29a. Certifier 29b. Signature and title of certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

NDRIHWEST

5401

200

OLD COURT ROS

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

HOSPITAR

29c. License number 29d. Date signed (Month, Day, Year) 00059736 Patrice

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WATSON

FITZPATHICK

31. Date filed (Month, Day, Year) JUN 2 0

DEBORAH

2. Registrar's Signature

8

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last **Physician** 5:50 AM 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Randallstown Randalktown 9109 Liberty Baltimore COMPSIS 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 05 31 5 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 49 58 MD Director 219-66-6147 Usual Residence of Decedent 10d. Inside City Limits 10a Stale 10b. County 10c. City, Town or Location 28a-f ehow the Mudical Examiner must be notified at 1 ☐ Yes 2 X No Director Randallstown Baltimore MD 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number ŏ U.S.A. iteme 23a Apt 202 21133 22 Coachman Ct. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Item ony injury or other traumatic event, the Martine 1000. Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Specify Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) US Postal Service Mail Sorter 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Frances Parker Henry Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 19a. Informant's Name/Relationship (Type, Print) 22 Coachman Ct. Apt 202, Randallstown Md Natalie King-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 6/20/07 Baltimore, Md 22. Name and Address of Facility
March F/H West 21 Signetule of Funeral Service Licensee 21215 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final di ease or condition resulting in death) Physician irchosi /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): physician s the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? á 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has autopsy performed? 1□ Yes 2 1 NO Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Cther: 4 ☐ Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 → Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. fnjury at Work? After Injury 1 Matural 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier t 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

or Attending Physician: The law requires that the death certificate be executed Box 68760, Division of Vital Records, P.O. ospital c. 4 hours after dea. --rai Director: Aftr 24 hours a To the within 2

Baltimore, Maryland 21215-0036

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Mamph D00564L Randalstown MD 21133 Liberty Road

State Registrar

31. Date filed (Month, Qay, Year)

ocelyn

9109 32. Registrar's Signature

			1 - For State Registrar Amend #1, perMD,	State of Marylan g869,7/12/07 T.		artment of interest of interest of			ene () () /	15525
	Dhusisi	_	1. Decedent's Name (First, Middle, Last)	D				2. Date of Death Month	Day Yea	3. Time of Death
	Physici /Medio		15etty An	in hae	Bett	y Ann Rea		06	13 200	
	Examin		4a. Facility Name (If not institution, give st	1			or Location of Deat	h	4c. County of De	eath
			Brightview Assi	sted Living	\	Caton	sville		Baltimo	re
	Funeral Director		5. Social Security Number 6. Sex 1 1	7. Age (<i>in yr</i> s. 85	last birthday) Yrs.	If Under 1 Year Months Days			Year)	Birthplace (State or Foreign Country) Aryland
	p ,		Usual Residence of Decedent 10a. State 10b. County	100 Cit	y, Town or Lo					10d. Inside City Limits
	anyla eho	<u>ا</u>								1 ☐ Yes 2√ No
	Ne N	ect	MD Baltimor	е	Cato	nsville		10	- Chi	
	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28a-f ehow the Medical Examinar must be notified at	급	912 S. Rolling Roa	ıd		TOI. ZIP CODE	21228		g. Citizen of What USA	
	ns 23	era		2. Was Decedent Ever in U	.S. 13.1	Was Decedent of	Hispanic Origin? (S	pecify Yes or No-	14. Race - A	nerican Indian,
_	fter d	표	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 1 No		f Yes, specify Cui	ban, Mexican, Puèr	to Rican, etc.)	Black, W	
3	er's a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🌠 No	Specify:		Specify:	white
2 Z 3-0030	72 ho	ted	15. Decedent's Educa (Specify only highest grade	ation	16a. Deced	dent's Usual Occu	ipation during most of wo	rt/inc	6b. Kind of Busine	ss/Industry
<u>''</u>	thin 7	pie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retir	ed)	King		
V	or th	Con	12	4	hos	spital vo	lunteer		healthca	ire
/and	a H H		17. Father's Name (First, Middle, Last)					me (First, Middle, M		
<u>x</u>	Ment Went	Ţ	Pierce Franklin	Kimmett			Rena Al	ice Mulro	ney	
Mar	2 she and ion	17 7	19a. Informant's Name/Relationship (Type		1			ural Route Number,		e, Zip Code)
e (e	and lealth m 27 her t		Brightview Nursing		_	S. Rollin	ng Road C	atonsvill		.228
5	if it of it		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	/	emetery, crer	natory or other pl	ace)	Date	loc. Location - City	or rown, State
	rtmer rtant:		4 Noperation 5 Other (Specify)				1			
<u>8</u>	Dependimbe		21. Si nature o Euneral Service Lic., ser Rona Ld. 8 W	ade, Director		ate Ana	tomy Boar	d 655 W.	Baltimore	Street
	_		23a Part 1. Enter the disease, or complic	ations that caused the deat			MD 212		st	Approximate
	Diam'r.	hes been signed by the ettending physician and important: if item 27 ie marked other than "naturel", or ite more despite the principle of the entending physician and entendin	shock, or heart failure. List only one Immediate Cause (Final	cause on each line.		-	-	, ,	·	Interval Between Onset and Death
Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence	Hansa of):	eart Fo	ulure				
				Coronary	Arte	in Disc	Dr. 1. C			
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	uence of):	1 0.30				
/	outed id ansit	Ë	Cause (Disease or injury that initiated events c.							
ĵ	an an an irial-tr	EX	resulting in death) Last	Due to (or as a conseq	uence of):					
2	ate be nysici he bu	Icai	€ d.							
٥	ng ph as th	Wed	IF FEMALE:							-
X Q	ith ce itendi	an/l	23b. Was decedent pregnant in the past 12 months?	 c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feta 		Ectopic pregnan	су		23d. Date of Month	delivery Day Year
<u>.</u>	the ent	sici	1 Yes 2 No	4☐Pregnant at time of c 9☐Unknown	leath 5	Other (specify)			WONT	Day (Bai
Z.	d by detacl		Part II. Other significant conditions cont	phyting to death but not res	ulting in the u	ndorkina cauco o	ivon in Part I	23e Did tob	acco use contribute	to the cause of death?
Records,	requires thet the death certifice is signed by the ettending thould be detached for use as	1 by	Tarri. Ottor significant conditions cont	industry to death but not les	alting in the u	indenying cause g	IV o il iti Fait i.		_	Probably 4 Unknown
Ö	been been shoul	etec								
ě	hes hes	ш						24a. Was an autopsy perform	24b. Were prior death	autopsy findings available to completion of cause of
	icien: The certificete hi rector, page							1 ☐ Yes 2	□ No 1 □ Y	es 2 No
VII		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:		0	thon	ath (Check only one		1/2/
ō	Phys rthis ral di	1 ⊢	27. Manner of Death	1 Inpatient 2	ER/Outpatier 28b. Time of	IL JUDON	4 🗆 Nursing r	dome 5 ☐ Reside		pecity) Assisted living
0	ding th. Afte	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	W	ork? ⊒Yes 2.⊒No			
UNISION	Attending or death.	ifica	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, str	eet, factory, office	9	28f. Location (Str	eet and Number or	Rural Route Number,
Ē	spital or Attending Phous effer death. Neral Director: After the filled in by the funeral	Certification;	4 Homicide determined	building, etc. (Special	y)			City or Town	, State)	
	합선 필수		(Check only 2 Medical Examin	cian: To the best of my kno er: On the basis of examina	wledge, death	h occurred at the vestigation, in my	time, date and place	e, and due to the ca urred at the time, da	use(s) and manner	as stated. due to the cause(s)
	To the Hos within 24 h To the Fur completely	Medicai	29b. Signature and title of certifier	and manner stated.			nse number		d. Date signed (Mo	
J.	5 2 E 8		JAN C						1 .	
1.	10		monde	some	7	U	005333	, 7	6/14/	07
1	7)		30. Name and address of person who in			+ Cir.	6 201 F	Reistersta	LM. nw	
	Sta	ate	31. Date filed (Month, Par, Vegr)	32. Registrar's Signa	lain S	and sur	TE COO	, (10	(1110	
	Regist		JUN 2 0 20	Ul Jan Shipine -	Mr Joh	OR BU				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 2007 110 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) if Under 24 Hrs. ran More ursina Birthplace (State or Foreign Country) Year Days 8. Date of Birth (Month, Day, June 5, If Unde 7. Age (In yrs. last birthday) 5. Social Security Number Min. Hours 1**X** M 2□ F Months Kansas Yrs. 149-22-1545 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1√∑Yes 2 ☐ No Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 35 N. Lakewood Avenue #207 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ♥ Divorced 51-53 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 4 <u>computer specialist</u> University of Alabama 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alice Holcomb William Rae 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joyce Zimmerman/friend 4200 St. Paul Street Baltimore, MD 21218 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖒 Other (Specify) in Stat in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signature of Europa al Service Licentee Ronald S. Wade, Director Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Chronc resulting in death) Due to (or as a consequence of): SWD Due to for as a gui sectiones of Due to (or as a consequence of):

Physician /Medical Examiner

attending physician and for use as the burial-transit

the detached

Ś

ector, page 2 should be

filled in by the funeral

Hospitel or Attending

death.

after death Director:

within 24 hours a To the Funerel D

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

1-

10a. State

Physician

/Medical

Examiner

Funeral

Director

or Items 23e or 28e-f show

"neturel"

at Hygiene.

of Health and Mental Hyg If item 27 is marked other or other treumatic event,

permit. Page Department of Importent: If any injury or once.

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

the Medical Examiner; out the notified at

Director

Completed by Funeral

Be

೭

Examiner

Physician/Medical

ģ

Completed

Be

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

9 Unknown

27. Manner of Death

1 Natural

2 Accident

3 🖺 Suicide

29a. Certifier

4 / Homicide

23d. Date of delivery 3 Ectopic pregnancy Month Day

IF FEMALE 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

5 Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Year

26. Place of Death (Check only one 25. Was case referred to medical examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

1 ☐ Yes 2 ☐ No

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

5 Pendina

investigation

determined

6 ☐ Could not be

29c. License number

29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

MD

h Raven Blvd. Baramon MD21239

State Registrar

DHMH 17 Rev 1/2001

100

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month **Physician** 2007 dNe /Medical Facility Name (If not institution, give street) and number, 4b City, Town, or Location of Death ounty of Death **Examiner** Bal Marc 5. Social Security Numbe Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 XM 2 □ F Davs Hours Min. Yrs. 52 **Director** 200-44 3402 6-18-1954 Clair. Pa Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f shother traumatic event, the Medical Examiner must be notified. 1 ▼Yes 2 □ No Schuylkill St. Clair Director PA. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17970 100 South Second St. USA death Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after Yes, Give 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify. White 2 If Yes, Give Year or Dates: 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs. Lawver Legal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Dr. Edward Ryscavage ဂ္ Kathleen Loftus 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trauonce. Dr. Thomas Ryscavage 2717 Eastwood Drive York, Pa. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Queen of the Universe 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Clair, Pa. 17970 6-19-2007 4 ☐ Donation 5 ☐ Other (Specify) Cemetery permit. 21. Signature of Funeral Service Licensee 7401 Belair Rd. 22. Name and Address of Facility 8.3. Lassahn Funeral Home Baltimore, Md. 21236 0 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, \$ 1 Yes 2 No 3 Probably ★ Inknown Completed Was al. autopsy performed? Yas 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s death? 1 ☐ Yes 1□ Yes 2 □ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: 2 No Other: 1 ☐ Yes P 1 ∰Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division Injury Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral C Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year)

5 State

DHMH 17 Rev 1/2001

State 31. Date filed (Month, Day, Registrar

JUN 2 0 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Alvssa Kristine Stecker State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day June 12, 2007 Medical Examiner 1514 hrs Alvssa K. Stecker 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8125 48th Avenue College Park Prince George's If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign West 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 06.18.1986 Director 485.08.3809 20 Country)Africa 2 XF М Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits College Park Yes 2 X No show MD Prince Georges Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20740 8125 48th Ave. Apt. 315 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married Yes 5 _{Specify:} White Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Yes 2 No specify: If Yes. Give Year Widowed 4 Divorced "natural" ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ it: If item 27 is marked other than "other traumatic event, the Medical 21215-0036 3 Student College 18.Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Carl C. Stecker Paula Leacox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 840 Gleneagles Dr. York, PA 17404 Paula Stecker/mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State tant: Yorktown Crematory 06.18.07 York, PA Donation 5 Other Specify: 22. Name and Address of Facilit Cremation And Funeral Balto 21. Signature of Funeral Service Licensee 8717 Green Pastures Dr. MD PER DVR Alternatives Lynda Sue Ritter 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and /Medical Death Fluoxetine and olanza ine intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine 12/5. (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed and Physician/Medical 23a,27,28a-f. perM Iten#21,perFH,6868, e attending physician a for use as the burial -AMENDED # X UNPENDED The law requires that the death certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Fetal death Month Year past 12 months' Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown g Unknown Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. ģ Yes 2 V No 3 Probably 4 Unknown Completed has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate ✓ Yes 2 No No 1 🗸 Yes r this certifical director, 1 the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital 26.Place of Death (Check only one) Be Hospital: 1 examiner? Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene 1 Yes 10 After 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Yes 2 X No To the Funcral Director: completely filled in by the Pending subject took drugs Fnd 6/12/2007 Fnd 3:05 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 24 hours after 3 X Suicide Could not be or Town, State) 8125 48th Ave. College Park, MD (Specify) Found at residence determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated **Medical** one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9 O.C.M.E. JUNE 13, 2007 OSLY OCME 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Mary G. Ripple MD. Deputy Chief Medical Examiner 31. Date filed (Month, Day, Year) egistrar's Signature State Registrar

DHMH 17 Rev 1/2001 **OCME 2006**

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 11:50 PM pencen 07 06 7 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Roland Park 4669 Falls Rd 6. Sex 7. Age (In yrs. last birthday) Itu BOLLIMOR MIN 12 Miller care 5. Social Security Number Date of Birth (Month, Dey Birthplece (State or Foreign Country) Funeral Days Min. Hours 18-2307A 1 M 2 X F Director UNKNOWA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1. Yes 2 No MARYLAND Director 10e. Street and Number 10g. Oitizen of What Country? # YLVANIA or Items 23a 1 and 2 should be filed within 72 hours after death 1 Health and Mentel Hygiene. em 27 te marked other than "natural", or Itams 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: þ 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) VRS MEDICAL JOURNALS injury or other traumatic event, 17. Father's Name (First, Middle, Last) (UNKING WN) 18. Mother's Name (First, Middle, Maiden Surname) (UNKNOSUN) Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 ie
any Injury or other trau 12 COMMONWEAL 5 BOSTON STEP-DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Burial 2 Cremation 3 Removal from State 4 □Donation 5 □ Other (Specify) OWINGS MILLS. MA 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility TR. FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** GLIOBLASTOMA MULTIFORME disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit the attending physicien and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No page 2 should be detached 9 Unknown 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? After this certificate 1 ☐ Yes 2 No 1 Tyes Physiclan: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3□ DOA funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 Pending Natural Injury Yes 2 No death. 2 Accidant investigation the Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours after To the Funeral Direct 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as statad.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier m.D 06-18-2007 0005910 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUSINESS UMA CENTER DRIVE REISTERST &WN MD 21136

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 0

32/Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Rochelle Slaughter ,2007 June 17 /Medical 9:00A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fallston 905 Dellwood Drive Harford 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** Days 1 ■ M 2 🗹 F Months Hours Min. 217.64.1793 54 Director 02.11.1953 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be notified to once. 10c. City, Town or Location 10d. Inside City Limits 10a, State MD Harford 1 ☐ Yes 2 ☐ No Director Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 905 Dellwood Drive 21047 U.S.A.

14. Race - American Indian,
Black, White, etc. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ 10 Specify: Completed by Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered_Nurse <u>Hospital</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bernard Smith Amelia Huber ం 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Slaughter 905 Dellwood Drive Fallston, MD 21047 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Chesapeake Crem. 06.19.07 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation And Funeral Balto 21. Signature of Funeral Service Licensee ON Alternatives 8717 Green Pastures Dr. MD 23a. Part1. Enforthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Orset and Death Immediate Cause (Final NETRSTATIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Ves 24 No certificate 1☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5th Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: After th filled in by the funeral 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) le #314 Boltimber 9110 Philoppi

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh 9868 6-20-07 vt. State of Maryland? Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 12 2007 Shields June 2:07P. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 141 Alberge Lane Middle River Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 XM 2□ F Yrs. Director 216-86-0089 38 08 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 Yes 2X No Director MD Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 141 Alberge Lane 21220 U.S.A. Funeral deeth 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes Ž ☐ No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black ģ 3 Widowed 4 Divorced 'naturel' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. 12th grade Housekeeping UMBC na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ith and Mental F 27 is marked of traumatic ever Pages 1 and 2 should be Sherman Kemp Florence Shields 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Depurtment of Health ar Important: If Item 27 is any njury or other trau once 141 Alberge Lane, Middle Rive, Md 212
a of Disposition (Name of Date 20c. Location City or Town, State Florence Sims-Mother Md 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 19 X□ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/18/2007 Randallstown, Md King Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md, 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ato **Physician** 405 /Medical Due to (or as a consequence of): Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Completed by Physician/Medical ed by the attending a IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗆 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Seesidence 6 Other (Specify) Certification; To this hours after death. uneral Director: After this y filled in by the funeral d 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a
To the Funeral C 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and attender certifier 29c. License number 29d. Date signed (Month, Day, Year) ou 30. Name and address of person wno completed cause of death (Item 23a) (Type, Print) 29 Tuly 31. Date filed (Month, Day, Year) 32 Aegistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician BLANCHE ELOISE** STEDTLER JUNE 18. 2007 5:30 FM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson Baltimore Saint Joseph Medical Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) Jan. 22–1917 6 Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🔀 F 90 Director 218-03-1290 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notifled at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes X No Director Marvland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n 9311 Old Harford Rd. 21234 USA Funeral 'natural', or items dical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 □ Yes 2**XX**No Specify: Completed by 3 X Widowed 4 □ Divorced permit. Pages 1 and 2 should be filed within 72 ht. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A Homemaking - Own Home 12 yrs. Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ James Curtis Thomas Beulah Louise Brandenburg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Thomas V. Stedtler (Son) 9311 Old Harford Rd. Baltimore, Md. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition X1X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 6-22-07 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility
Lassahn Funeral Home
7401 Belair Rd. Bal 21. Ignature of Funeral Service Licensee Baltimore, Md. 21236 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for us in the past 12 months? 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2綦 No autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 27. Manner of Death 1 ⚠ Natural 28a. Date of Injury (Month, Day Year) After t 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: To the Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 3☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier 29c. License number 29b. Signature and title of certific

20 State Registrar

Baltimore, Maryland 21215-0036

Box 68760,

o

Δ.

or Vital Records,

Division

DHMH 17 Rev 1/2001

7601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D.

egistrar's Signature

Date filed (Month, Day, Year)

JUN 2 0

31. Date filed (Month, Day,

D 17695

OSLER DRIVE.

TOWSON, MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITM/5, 9 per FH, C809, 7/9/07, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 16 2007 **Physician** Florence Marine Smith 5:44 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Towson Baltimore 5. Social Security Nation 217 34 4927 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day Year) June 20 1919 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. Months Pierce, W.V 1 □ M 2 □ F 87 **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Baltimore City Baltimore 1 XYes 2 No Director 10f. Zip Code 21206 10e. Street and Number 10g. Citizen of What Country? 3524 Glenmore Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2111 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes XX No Specify Completed by ₩ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7; th and Mental Hygiene. 7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Nurses Assistant Johns Hopkins Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Homer Kight Lottie Fitke 2 19a Informant's Name/Relationship (Type. Print)
Clifford Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 3524 Glenmore Avenue Baltimore, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages ' 1 Hurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Eglon Cemetery June 18 2007 Eglon , West Virginia 22. Name and Address of Facility Lassahn Funeral Home Inc 21. Signature of Funeral Service Licensee Mathee 7401 Belair Road Beltimore, Maryland 21236 23a. Part1. Enter the disease, **Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** UNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi Due to (or as a consequence of): attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknow signed by the ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed' After this certificate Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ Division or Manner of Death 28a. Date of Injury 28b. Time of funeral 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation M neral Director: / 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0, TARIQ 2300 Dulaney Valley MAH MOOD Rd. Timonium, Md 31. Date filed (Month, Day) 32. Régistrar's Signature State Registrar

B

200

W

			For State Registrar				ertificate o	Health and f Death		Reg. No.	JJI	13007			
	Physicia /Medic	_	1. Decedent's Name (First, Mic GEOLGE	R. Sch	INEID	ER	SR.		2. Date of De Month	19 a	Year 2007	3. Time of Death 7.49 A M			
	Examin	er	4a. Facility Name (If not institute BALTIMORE WA			AL CENTE		n, or Location of Deat SURNIE	th		nty of Death	TY			
	Funeral Director		5. Social Security Number 212-28-6798	6. Sex 1 ☑ M 2 □	7. Age (In	yrs. last birthda 81 Yrs.	y) If Under 1 Ye Months Da	ar If Under 24 Hrs			9. Birth	place (State or Foreign htry) MD			
	yland sow at		Usual Residence of Decedent 10a. State 10b. Cour	nty	100	c. City, Town or	Location					10d. Inside City Limits			
	ne Mar 8a-f sh otified	Director		nne Arund	e1			asadena		40 000	1 ☐ Yes 2√N Dg. Citizen of What Country?				
r,	death with the Maryland ms 23a or 28a-f show r must be notified at	al Dire	10e. Street and Number 338 Somerse	t Road			10f. Zip Cod	21122		10g. Citizen	USA	ntry ?			
<i>ઝ</i> . જ્ર ડ)	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyjene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2□ 3 □ Widowed 4 □ Divorce	arried Armed	Decedent Ever d Forces? es 2 No , Give or Dates:	in U.S. 13	B. Was Decedent If Yes, specify C 1 ☐ Yes 2 ☒ I	of Hispanic Origin? (S cuban, Mexican, Puer No <i>Specify:</i>	Specify Yes or Norto Rican, etc.)	E	14. Race - American Indian, Black, White, etc. Specify: White				
21215-003	vithin 72 hoi sne. than "naturi ie Medical E	To Be Completed	15. Deced (Specify only hig Elementary/Secondary (0-12	ent's Education hest grade complet	red) ge (1-4or 5+)		cedent's Usual Oc ve kind of work do DO NOT use re	cupation ne during most of wo lired)	orking		16b. Kind of Business/Industry Automotive				
606 Ind 21	be filed v ntal Hygie d other t event, th	Be Co	17. Father's Name (First, Midd	_{lle, Last)} nnei der			aco nech		me (First, Middle						
Paryla	2 should and Mer Is marke raumatic	P.	John Sch 19a. Informant's Name/Relation Evelyn J. Schi	onship (Type. Print)	spouse)	19b. Ma	iling Address (Str.	eet and Number or A et Road,	Rural Route Numi	ber, City or To	wn, State, Zi _i	o Code)			
Sc <i>Hい6iひ6に Geo</i> Baltimore, Maryland	ages 1 and nt of Health : If Item 27 or other t		Oa. Method of Disposition Disposition Disposition Disposition Date Disposition Date Disposition Date Disposition Date Disposition Date Disposition Date Disposition Date Disposition Date Disposition Date Disposition Date Disposition Date Disposition Date Disposition Date Disposition Date Disposition Date Disposition Date Disposition Date Disposition Date Disposition D												
3altin	permit. Pa Departmer Important any Injury once.			1. Signature of Funeral Service Discrisee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122											
S			23a. Part1. Enter the disease shock, or hear ailure. I	or complications the list only one cause	nat caused the on each line.	death. Do not e	enter the mode of	dying, such as cardia	ac or respiratory	adena ,_ arrest,	MD 21	Approximate Interval Between Onset and Death			
	Physician /Medical Examiner		disease or condition resulting in death)	a	to (or as a cor	nsequence of):	e Ca	HYCARDIA PDIOMYOR ERY DI	71744			IMPNEDIATE 2 WEEKS			
2	be tis	iner	Se juentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Dui	to (or as a col	nsequence of).	, Do-	Equ D	50100	-		2 weeks			
68760, 6	ficate be executed physician and s the burial-transit	edical Examiner	that initiated events resulting in death) Last	cd.	e to (or as a con	nsequence of):	NE		ISEASC						
P.O. Box 68	attending for use a	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□L 4□P	i, outcome pf prive birth 2 Pregnant at time	Fetal death	3 □Ectopic pregni 5 □ Other <i>(specif</i>)			23d.	Date of delive	rery Day Year			
rds, P	N requires that the dispension been signed by the should be detached	by	Part II. Other significant cond	ditions contributing	to death but no	ot resulting in the	underlying cause	given in Part I.			contribute to o 3 ☐ Pro	the cause of death? bably 4 ⊠Unknown			
Division or Vital Records,		Completed							24a. Wa aut per 1∐ Yes	opsy formed?	prior to co	opsy findings available ompletion of cause of			
Vita	ysician: is certific director,	Be	25. Was case referred to med examiner? 1 ☐ Yes 2 ☒ No	Haanital	1 🗆 Innation	2 ☐ ER/Outpat	ient 3 DOA	Othor:	eath <i>(Check only</i>		Other (Spec	i6./\			
n or	Attending Physician: r death. ector: After this certifics by the funeral director, I	on: To	27. Manner of Death 1 Natural 5 ☐ Per	28a. I	Date of Injury Month, Day Ye	28b. Time	e of 28c.	Injury at Work?		e how injury oc					
Divisio	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	Certification:	3 Suicide 6 □ Cou	estigation uld not be ermined 28e. F	Place of injury - ouilding, etc. (S	At home, farm, specify)	M street, factory, off	1 ☐ Yes 2 ☐ No ice	28f. Location City or To	(Street and No	umber or Ru	ral Route Number,			
	e Hospital or 24 hours afte e Funeral Dir letely filled in l	Medical C	29a. Certifier 1X Certi (Check only one) 2 Medi	cal Examiner: On t	o the best of m the basis of exa manner stated.	amination and/o	eath occurred at the rinvestigation, in	ne time, date and pla my opinion, death oc	ce, and due to th	e cause(s) and e, date and pla	d manner as ace, and due	stated. to the cause(s)			
	To the within 2 То the сотрые	Me	29b. Signature end title of cer	tifler	(m)			cense number 000 \$891	4	29d. Date si	gned (Month	, Day, Year) 7 2007			
	5+1		30. Name and eddress of personal H.	A YALA M	cause of death	(Item 23a) (Typ	DISON F.	nex Dein	E Gue	N BUR	2N1E	7 2007 MD 21061			
	Sta Regist	ate rar	31. Date filed (Month, Day, Ye JUN 2	0 2007	32 Registrar's	Signature	barte								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day PM 10 2007 June 16, James Edward Schammel, Sr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday Days Months 1 M 2 □ F Yrs 84 216-14-7894 22, 1922 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 👿 No Maryland Baltimore Perry Hall 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 8605 Hickory Thicket Pl. 21236 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Oil Company 12th. Grade Fuel Dispatcher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Schamme1 Christian Marie Clark 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Schammel, Jr./Son 8605 Hickory Thicket Pl MD 21236 Baltimore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 06/19/2007 Metro Crematory Baltimore MD 22 Name and Address of Facility 21. Signature of Funeral Service Licens Miller-Dippel Fur 6415 Belair Road Funeral Home, oad Baltimore 21206 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death) 2 Days ulmonary Due to (or as a con-equence of): Arter Unknown Due to (or as a consequence of) Squeritally not condition, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Preumonia, CVA, Seizure Disorder, Anemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Kidney Diseast 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed?

1 Yes 2 M No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ms 23a or 28a-f show must be notified at

7 Is marked other than "natural", or items. traumatic event, the Medical Examiner mu

ges 1 and 2 should be file it of Health and Mental Hy If item 27 Is marked oth

Pages 1 Department of Important: If it any Injury or c

be executed

Box 68760.

P.0.

Division or Vital Records,

or Attending

Director

Funeral

Completed by

Be

2

death with the Maryland

burial-tran attending physician for use as the buria signed by t page 2 s

Examiner

Physician/Medical 2

this certificate funeral After within 24 hours after community to the Funeral Director: After community of the further of the f

in the past 12 months? 9 Unknown Completed 25. Was case referred to medical Be 1 Yes 2 No 2 27. Magner of Death Certification: 5 Pending 1 Natural 2 Accident 3 ☐ Suicide

investigation 6 Could not be determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

4 Homicide

(Check only one)

29a. Certifier

Medical

State Registrar

Franklin Sq. Drive baltimore md 21237 9000 32 Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 2 per doc 8869 7-6-07 vt.
State of Maryland & Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death JUNE 15 Da 2007 ear **Physician** JAMES C. THOMPSON 7:00 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE CITY 2907 BOARMAN AVENUE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours BARBADOS WEST IND 1**⊠**M 2□F 092-76-8846 78 02/09/1929 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count BALTIMORE CITY N/A MD 1 XYes 2 No Director 10e. Street and Number 2907 BOARMAN AVENUE 10g. Citizen of What Country? 10f. Zip Code 21215 Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 **X**No If Yes, Give Year or Dates: Specify: BLACK 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ST. MARY S GIRLS 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOME BUILDING MANAGEMNET 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HILDA THOMPSON JAMES SMALL ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) WAYNE ROCK / SON 3609 LAUREL VIEW COURT, LAUREL, MD 20724 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/23/07 CATONSVILLE, MD METRO CREMATORY 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, 21. Signature of Funeral Service Licenses ther the disease, or complications that caused the death, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death . Do not enter the mode of dying, such as cardiac or respiratory arrest, Immedi e use (Final disease condition Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner as the burial-tran Due to (or as a consequence of) The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident within 24 hours after death

To the Funeral Director;
completely filled in by the f 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitai 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 31. Date filed (Month, Day, Year) State JUN 2 0 2007 Registrar

		1 - State Of Maryland / I	Certificate of Death	Reg.	2114 1965				
Physici /Medic		Decedent's Name (First, Middle, Last) LILLIAN	TAYLOR	JUNE 1	Day Year 7:50 P M				
Examin		4a. Facility Name (If not institution, give street and number) JEWISH CONVALESCENT CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last bit number)	Months Davs Hours Min.	8. Date of Birth	4c. County of Death BALTIMORE 9. Birthplace (State or Foreign Country)				
Director		216-32-6617 1 □ M 2 □ F 94 Usual Residence of Decedent 10b. County 10c. City, Tow	Yrs.	05/19/191	3 NC 10d. Inside City Limits				
th the Mary or 28a-f sho e notified a	Director	MD BALTIMORE B	BALTIMORE 10f. Zip Code		1 Yes 2 No				
be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	7 SLADE AVENUE APT. #608 11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	21208 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerlo		U.S.A. 14. Race - American Indian, Black, White, etc. Specify: WHITE				
ed within 72 houygiene. Ygiene. Ter than "naturation to the Medical Et, the Medical Et,	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) PROPRIETOR	king	MENS CLOTHING				
	To Be	17. Father's Name (First, Middle, Last) JACOB 19a. Informant's Name/Relationship (Type. Print) 19	SUGAR JENNIE bb. Mailing Address (Street and Number or Ru.	G	BERESONSKY				
C, Mal yiel		JEROME TAYLOR / SON 8 20a. Method of Disposition 20b. Place	8622 TIERRA LAGO COVE	- LAKE WO					
permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or other tra once.			MORE HEBREW CONG 06/3 22. Name and Address of Facility SO 8900 REISTERSTOWN	L LEVINSON	& BROS., INC.				
The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate by the attending physician and an are larged by the attending physician and are larged by the detached for use as the bunal-transit	edical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	sis e of): Sacral decubitu e of):		3 days				
the death certific the attending proceed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown			23d. Date of delivery Month Day Year				
law requires that as been signed by 2 should be deta	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting Ambulatory dysfunct		1 □ Yes 24a. Was an	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available				
VICAL INC ician: The la certificate has ector, page 2	a	25. Was case referred to medical	26. Place of Dec	autopsy performe 1 Yes 2 L ath (Check only one)	prior to completion of cause of death? No 1 □ Yes 2 □ No				
To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	ation: To B	1 ANatural 5 □ Pending (Month, Day Year) investigation (Month, Day Year)	o. Time of lnjury at Work? M 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how					
pital or Att urs after de eral Direct	Certification:								
To the Hos within 24 ho To the Fund completely f	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated. 29b. Signature and other of certifier	and/or investigation, in my opinion, death occu	urred at the time, date	e and place, and due to the cause(s)				
		30. Name and address of person who completed cause of death (Item 238 2 4 3 4 W BELVEDERE A	DO05392 a) (Type, Print) SURALYA P VE, BALTI MORE	BEGUM,	MD 21215				

State Registrar 31. Date filed (Month, Day, Year)

JUN 2 0 2007



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1	0	1 7		84:	
Lun	U	17	1 -	0	

Emerson Craig Telford Certificate of Death 1- For State Reg. No 3. Time of Death Registrar 2 Date of Death 1. Decedent's Name (First, Middle,Last) June 15, 2007 Physician/ 0915 hrs Examiner Telford Craig Emerson 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Calvert Owings 3511 Hall Creek Lane 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months Days 08/20/1963 Country) PA 43 Director 159-60-7609 1 XM 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 X Yes 2 No Greensburg Westmoreland 23a or 28a-f show notified at once. PΑ t Pages I and 2 should be filed within 72 hours after death with the Maryland rance of Health and Mental Hygiene reant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the M-dical Examiner must be notified at once. 10g. Citizen of What Country? Director 10f. Zip Code 10e. Street and Number United States 15601 18 Windihill 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 12. Was Decedent Ever in U.S. 11. Marital Status Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 X Never Married 2 Married 2 X No Yes Specify: White 1 Yes 2 X No specify: 3 Widowed Divorce If Yes. Give Year 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry þ 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) ALMAS Shrine MD 21215-0036 Building Recorder 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emerson C. Telford

19a. Informant's Name/Relationship (Type, Print) Mary E. Orris Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address 18 Windihill, Greensburg, Pennsylvania 15601 Michael D. Slavin, Partner 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date Baltimore, Permit Pages I and Department of Healt 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State June 20,2007 Delmont, Pennsylvania Twin Valley Memorial Park Donation 5 XOther Specify: Entonoment 22. Name and Address of Facility Barnhart Funeral Home 21. Signature of Funeral Service Licensee M01113 505 Fast Pittsburgh Street, Greensburg, PA 15601 23a. Part I. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and nysician failure. List only one cause on each line. Death a. Atherosclerotic Cardiovascular Disease Medical Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical AMENDED UNPENDED attending physician for use as the burial -23d. Date of deliver Box 68760. 23c. If yes, outcome of pregnancy IF FEMALE: Year Day Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown signed b by 24b. Were autopsy findings available Completed 24a Was an prior to completion of cause of autopsy death? performed? has page 2 s 2 No ✓ Yes 2 No 1 Yes After this certificate he Hospital or Attending Physician: TI nn 24 hours after death. he Funeral Director: After this certifica bletely filled in by the funeral director, p? 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other: Nursing Home 5 Residence 6 ✔ Other: Scene examiner? Hospital: 4 DOA Inpatient 2 ER/Outpatient 3 1 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Yeer) 28b. Time of Injury 27. Manner of Death Certification 1 V Natural 1 Yes 2 No Pending Investigation 28f. Location (Street and Number or Rural Route Number, City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Could not be 3 Suicide determined (Specify) 4 Homicide 29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal within 2 To the ! Medi and manne stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signat June 16, 2007 O.C.M.E. 30. Name and address of person who com leted cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Susan Hogan MD. 32 egistrar's Signature 31. Date filed (Month, Day, Year) State Registrar DCME

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2007 7:00 A M June 15, Robert Douglas Womack /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Anne Arundel Brooklyn Park 6950 Baltimore-Annapolis Blvd. 8. Date of Birth (Month, Day, Yeer)
Dec. 22,] If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Hours **Funeral** 1**2**M 2□ F 1952 Maryland 54 213-64-4398 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene. and to them than "natural", or items 23a or 28a-f show ant: if item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 No Brooklyn Park Directo Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21225 United States 6950 Baltimore-Annapolis Blvd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Brick Mason Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Virginia P. Towles James Wm. Womack, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 602 Old Hammonds Ferry Rd., Linthicum, MD 21090 Virginia Moore / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) June 18, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 2007 Elkridge, Maryland permit. Page Department of Important: if any injury or 21. Signature of Funeral Sen e Licen e Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 ar Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Deat Immediate Cause (Final disease or condition ew Mosth Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ente burial-tran and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a Yes 2 No 9 Unknown 9 🗀 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ should be 1 Yes 2 No 3 Probably 4 Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No certificate Division of Vital To the Hospital or Attanding Physician: within 24 hours after death.

To the Funaral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA ို 1 🗌 Yes 2 NO 1 🗀 Inpatient 28d. Describe how injury occurred 27. Manne Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? Certification: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 18 00404 0 21050 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 518 S. CAMP Meade MD 32. Registrar's Signature 31. Date filed (Month, State Esters.

Registrar

				1 - For State Registrar	State of Ma			Health and N	lental Hyg	giene 2 0 0 7	19843
		Physici	an	1. Decedent's Name (First, Middle, L	ast)				2. Date of Dea	Day Year	3. Time of Death
		/Medic		ROSE ANTOIN		H			June 18	3, 2007	10:30P M
		Examin	er	4a. Facility Name (If not institution, g Stella Maris			Timon				imore
		Funeral Director		5. Social Security Number 218-32-4595 Usuaf Residence of Decedent		(In yrs. last birthday 90 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) June 13	Year) 9. Birth Cou , 1917 Mar	place (State or Foreign intry) y l and
		nand ow		10a. State 10b. County		10c. City, Town or L	ocation.		<u> </u>		10d. Inside City Limits
		the Man 28e-f eh	rector	Maryland Baltim	ore	Timonium	10f. Zip Code		1	log. Citizen of What Cou	1 Yes 2 No
		th with	al Di	1814 Savo Court				093		USA	,
. M		-ms	iner	11, Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13	Was Decedent of H	lispanic Origin? (Sp an. Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
:30 P	215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Items 23a or 28e-f show event, it a Mudical Examination investor notified at	To Be Completed by Funeral Director	1 Never Married 2 Married	1 ☐ Yes ②XXNo If Yes, Give Year or Dates:		1 □ Yes XX No	Specify:			White
:07	5-("natu	lete	15. Decedent's l (Specify only highest g	Education rade completed)	16a. Dec	edent's Usual Occup e kind of work done DO NOT use retired	ation during most of work	ing	16b. Kind of Business/Ir	ndustry
	212	withir ene. than	duic	Elementary/Secondary (0-12)	College (1-4or 5+)	eautician			Beauty	
		filed with Hygiene. other than	e C	17. Father's Name (First, Middle, Las	(t)		caucician		e (First, Middle, I	Maiden Sumame)	-
7	ılan	Menta Menta arked atic ev	To B	Anthony Shilback				Sop	hie R <mark>ay</mark> r	mond	
2007	Maryland	ges 1 and 2 should it of Heelth and Mer it If Item 27 is marke or other treumatic		19a. Informant's Name/Relationship Roseann Walsh-Hi			ing Address (Street Savo Cou			r, City or Town, State, Zingyland 2109:	
18,	Je,	of Hee of Hee fitem r othe		20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other place	ce)	Date	20c. Location - City or T	own, State
Œ	Ē	nit. Pages pertment of ortant: If It injury or o		1 ☐ Burial XX Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Hemoval from State	GreenMou	nt Cremat	ory 6/20	/07	Baltimore	, Maryland
JUNE	Baltimore,	permit. Page Depertment Important: II any injury o		21. Signature of Funeral Service	ishan Pu	akin				defeld Funeral re, Maryland 2	
				23a. Part1. Enter the disease, or coshock, or heart failure. List only	mplications that caused to	he death. Do not er	nter the mode of dyir	ng sich as cardiac	or respiratory arm	est,	Approximate Interval Between
	4	Physician	2 16	disease or condition	Cen	DEN 2/-38	ed II	2/210	5400	3-5-5	Onset and Death
		/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
1		pet nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or infury that initiated events	b. Due to (or as a	consequence of):					
V	760,	be executed sicien and burial-transit	il Exar	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
	687	# × #	dical	•	d						
	Box	Physician: The law requires that the death certifica this certificate has been signed by the attending ph at director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 monthe? 1 □ Yes 2 → No 9 □ Unknown	23c. If yes, outcome or 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	☐Fetaf death 3	□Ectopic pregnancy	/		23d. Date of deliv Month	reny Day Year
	P.0	that If	/ Ph	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause giv	ren in Part I.	23e. Did tot	bacco use contribute to	the cause of death?
	Vital Records,	uires n sign	d b	Part II. Other significant conditions					1 □ Ye	es 2□No 3□Pro	bably 4 Osknown
	Ö	s bee	Completed	Sterel	4/22				24a. Was a	in 24b. Were aut	opsy findings available
	R	The law cate has page 2:	mo						autops perforr	prior to come ? death?	ompletion of cause of
SE	ita	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Deat			2 140
ROSE	>	hysic his ce	10	1 ☐ Yes 2 No	Hospitaf: 1fnpatient	t 2 ☐ ER/Outpatie		4 Nursing Ho	me 5□Reside	ence 6 Other (Speci	fy)
'HS		Attending P r death. ector: After t by the funera	atlon;	27. Manner of Death Alatural 5 Pending Pen		Year) 28b. Time Injury	Wor	yat k? Yes 2 □No	28d. Describe ho	ow infury occurred	
WALSH	Division	<u>p</u> et <u>p</u> ∈	Certification;	3 Suicide 6 Could not determine	28e. Place of Injur building, etc.	y - At home, farm, s (Specify)	treet, factory, office		28f. Location (St City or Town	treet and Number or Rur n, State)	al Route Number,
		To the Hospitel within 24 hours a To the Funeral completely filled	Medical (29a. Certifier Sertifying F (Check only one)	Physician: To the best of the basis of each manner state	xamination and/or i	th occurred at the tir nvestigation, in my o	me, date and place, ppinion, death occur	and due to the cared at the time, d	ause(s) and manner as a late and place, and due t	stated. to the cause(s)
		within To th	Me	29b. Signature and title of permier	10 Solan	1 Res	29c. Licens	e number	2	9d. Date signed Nonth,	Day, Year)
		,			BOTT CE	(1	155	ا مرد ن	6/19	07.
		6		30. Name and address of person who							
				EDDIE NAKHUDA, 31. Date filed (Month, Qay, Year)	M.D. 2	300 DULAN	EY VALLEY	ROAD 1	TIMONIUM	MD 2109	3
		Sta Registr	-0.5	JUN 2 0	2007 Spenistrati	3 Signature	barre				

7-04611 homas John Zurek		artment of Health and Mental Hy	s Are Legible. ⁄giene
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	rtificate of Death	Reg. No. 2. Date of Death Month Day Vear Location And Control of Death Very 16, 2007 2055 hrs
Medical Examiner	Thomas John Zurek 4a. Facility Name (if not institution, give street and number) Johns Hopkins Hospital	4b. City, Town, or Location of Death Baltimore	June 16, 2007 2055 firs 4c. County of Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. 218–58–2836 1 1 1 1 5 5		Farcian
nd slow any: <u>cce.</u>		y, Town or Location	10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	10e. Street and Number 116 S. Wolfe Street	10f. Zip Code 21231	10g. Citizen of What Country? United States
r death wi	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No lift Yes, Give Year or Dates:	J.S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Inst. If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner To Be Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of v during most of working life. DO NOT use reti	
21215-0036 21215-0036 Methal Hygiene, marked other than ic event, the Medical TO Be Comple	12 17. Father's Name (First, Middle, Last) F.dward Zurek	18.Mother's Name Theresa	(First, Middle, Maiden Surname) Ginski
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event, To Be	19a. Informant's Name/Relationship (Type, Print) Theresa Warner / Mother 20a. Method of Disposition 20b		Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21231 Date 20c. Location - City or Town, State
Baltimore, permit. Pages I ar Department of Hei Important: If ite	1 Removal from State		21/2007 Baltimore, Maryland vid J. Weber Funeral Homes PA
Balti Depart Import injury	23a. Part I. Enter the disease, or complications that caused the deat failure. List only one cause on each line.	401 S. Chester Str	eet Baltimore, Maryland 21231
Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Methadone intoxi Due to (or as a consequence		Death
ecuted and transit al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence c. Due to (or as a consequence d.		
ial ial	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pre	egnancy 2 Fetal death 3 Ectopic pregna	23d. Date of delivery ancy Month Day Year
	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not	J Other (opecary)	23e. Did tobacco use contribute to the cause of death?
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial edical Certification: To Be Completed by Physician/Medic			1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
of Vital R g Physician: 1 ther this certific teral director, p	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 28a. Date of Injury	26. Place of Death (Check ER/Outpatient 3 DOA Other; Nursi 28b. Time of Injury 28c. Injury at Work?	only one) ng Home 5 Residence 6 Other: Scene 28d. Describe how injury occurred
Division of Vital Rec To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page ledical Certification: To Be Con	1 Natural 5 Pending Investigation 3 Suicide 6 X Could not be determined 4 Homicide (Month, Day, Year) Pending Investigation 5 Fnd 6/16/2007 28e. Place of Injury - At (Specify) House	t home, farm, street, factory, office building, etc.	unk 28f. Location (Street and Number or Rural Route Number, City or Town, State) 116 S. Wolfe St. Baltimore, MD
To the Hospita within 24 hours To the Funeral completely fille	one) 2 Medical Examiner: On the basis of examination and manner stated.	edge, death occurred at the time, date and place, and and/or investigation, in my opinion, death occurred	at the time, date and place, and due to the cause(s)
	29b. Signature and title of certifier When the	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) June 17, 2007
	30. Name and address of person who completed cause of death (Ite Margarita Korell MD. Assistant Medical Exam 31. Date filed (Month. Day. Year) 32. Restrar's Sign	niner 111 Penn Street, Baltimore, MD	21201
State Registra	1111 0 0 0007	A Line	

ORIGINAL

07-04114

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Ricky Atkinson, Jr. Certificate of Death 1- For State Reg. No Registrar Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day May 30, 2007 Physician/ 2158 hrs Medical Examiner Ricky Atkinson Jr Devonne 1c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hospital Center 8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State or Foreign Washington If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days :Hours Country) D.C. 06/01/ Director 1 X M 2 F 10 216-47-4718 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No s 23a or 28a-f show a notified at once. Prince George' Hyattsville Md with the Maryland 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 4816 Woodlawn Dr 20784 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral White, etc. or items Armed Forces? 1 X Never Married 2 Married 2 X No Yes Specify: Black Yes 2 X No specify: Yes, Give Year 4 Divorced hours after 3 Widowed \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) it. Pages 1 and 2 should be filed within 72 hou. tenent of Health and Mental Hygiene. Completed Elementary/Secondary (0-12) College (1-4 or 5+) none none 5 + h18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michelle Alston Ricky Devonne Atkinson Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 19a. Informant's Name/Relationship (Type, Print) 4816 Woodlawn Dr. Hyattsville, Md 20784 Tammy Forte -Guardian 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Washington, DC Baltimore, Glenwood Cemetery 06/09/07 1 X Burial 2 Cremation 3 Removal from State mportant Donation 5 Other Specify: 22. Name and Address of FacilitySnead Mortuary Service, P.A. 21. Signature of Funeral Service Licensee Bowie, Md 20721 1409 Fairlakes Pl Ste B 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Physician Death **Medical** a. Multiple Injuries Immediate Cause (Final disease .amine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical ling physician a UNPENDED #8perFH6/6/07, BMW, MoCo The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth past 12 months? Pregnant at time of death use 5 Other (Specify) Yes 2 No 9 Unknown Unknown the 23e. Did tobacco use contribute to the cause of death? ached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö Yes 2 ✓ No 3 Probably 4 Unknown à σ, 24b. Were autopsy findings available Completed of Vital Records. 24a. Was an s been s prior to completion of cause of autopsy death? performed? 1 🗸 Yes 2 No ✓ Yes 2 certificate 26.Place of Death (Check only one) 25. Was case referred to medical I or Attending Physician: after death. Be Other; Nursing Home 5 Residence 6 Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA this 1 🗸 Yes ٩ 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury 28b. Time of Injury After 27. Manner of Death Pedestrian struck by auto Certification: May 30, 2007 2109 hrs Yes 2 ✔ No Natural Division To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 5 Pending the 2 🗸 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. p or Town, State) Annapolis Road and Woodlawn Drive, Landover Hills, M 3 6 Could not be Suicide determined (Specify) Major Road / Highway Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 31, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. 32 Registrar's Signature 31. Date filed (Months Day, Me State 8

Registrar

			State of Maryland / Dep	artment of Health and N		-	1 - 71.		
			Registrar	rtificate of Death	1	leg. No. 🦾 🖰 🗸 1			
	Physicia	an I	1. Decedent's Name (First, Middle, Last) Elsie J. Applegate		Date of Dea Month	ith Day Year	3. Time of Death		
	/Medic		nisic of Appregate		June	4, 2007	10:00 A ^M		
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death			4c. County of Death		
		G.	Mariner Health of Bethesda	Bethesda If Under 1 Year If Under 24 Hrs.	8. Date of Birtl	Montgome			
	Funeral		5. Social Security Number 6. Sex 1 □ M 2 ▼ F 7. Age (In yrs. last birthday 98 Yrs.	Months Days Hours Min.	(Month, Day	r, Year) Co	hplace (State or Foreign untry)		
	Director		319-05-4707 Susual Residence of Decedent		Mar. 18	, 1909 Mass	sachusetts		
	and t		10a. State 10b. County 10c. City, Town or L	ocation		-	10d. Inside City Limits		
	f sho	ō	Maryland Montgomery Bethesda				1 X Yes 2 ☐ No		
	28a	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	untry?		
3	ours after death with the Marylar ral", or items 23a or 28a-f show Examiner must be notified at		5721 Grosvenor Lane #265	20814	TI	nited State	2 9		
	ms 2;	Funeral		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto			rican Indian,		
	r iter	Ē	1 □ Never Married 2 □ Married 1 □ Yes 2 □ X No		o Hican, etc.)				
3	ursa al',o	þ	3 XWidowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 21K No Specify:		Specify: Wh	ıte		
5	atur ical i	ted	15. Decedent's Education 16a. Deci (Specify only highest grade completed) (Giv.	edent's Usual Occupation	kina	16b. Kind of Business/	Industry		
	e. an "r Med	ed.	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of wor DO NOT use retired)	w/g				
1	illed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Homes	maker		Own Home			
	al Hy	Be (17. Father's Name (First, Middle, Last)			Maiden Surname)			
3	should be and Mental smarked of umatic eve	ဥ	Gustavus F. Weinstein	Marie Sc					
5	and ls ma		19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ing Address (Street and Number or Ru	ral Route Numbe	er, City or Town, State, 2	Zip Code)		
	and ealth n 27 ner tr			Briley Place Beth					
5	Pages 1 nent of He int: If iter iry or oth			osition (Name of ematory or other place)	Date	20c. Location - City or			
	Pag ment ant: ury o		4 Donation 5 Other (Specify) National				h, Virginia		
ָ ק	permit. Pages 1 and 2 should be liled within 72 no Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical J once.			22. Name and Address of Facility JC					
_	20 2 2 3	1	w. oggog / wolder						
	100		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death		
F	hysician		Immediate Cause (Final disease or condition a PNEUMONIA				011001 4110 20411		
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	- CO. JOH NA					
			Sequentially list conditions, b. CONEESTVE	CARDIONY	SPATHY				
_		Examiner	if any, leading to infinediate cause. Enter Underlying Cause, (Disease or injury)						
	be executed ician and burial-transit	хап	that initiated events resulting in death) Last C						
5	eath certificate be executed attending physician and I for use as the burial-transit	calE	200.00 (0.000 200.0000 200.000 200.000 200.00000 200.0000 200.000 200.000 200.0000 200.000 200.000 200.000 200.						
2	phys the		d						
<	certiff ding se as	sician/Medi	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d, Date of de	iven		
3	atten for u	cian	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		Month	Day Year		
5	the d	ysi	1 ☐ Yes 2 🛱 No 9 ☐ Unknown						
	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	/ Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?		
3	uires 1 sign 1d be	d by			1 🗆 🗅	res 20 No 3□P	robably 4 🗆 Unknown		
5	w req	lete			24a, Was	an 24b. Were a	utopsy findings available		
ב	he la has ge 2	Completed			autor perfo	osy prior to rmed? death?	completion of cause of		
0	n; T ificate or, pa	-	25. Was case referred to medical	26. Place of Dea	1 Yes	A	2 □ No		
>	sicia cert irect	o Be	examiner? 1 Yes 2 No	Lou		dence 6 Other (Spe	oifu)		
5	Phy ar this eral d	-	27, Manner of Death 28a. Date of Injury 28b. Time			now injury occurred	City)		
5	th: Afte	tiol	1 Matural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	M 1 ☐ Yes 2 ☐ No					
2	Atte	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (S City or Tox	Street and Number or R	ural Route Number,		
5	al or	Certification:	a building, etc. (Specify)		Only or rov	vii, State)			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier (Check only (C						
	the H iin 24 the F	ledical	one) and manner stated.						
	To T	Σ	29b. Signature and title of certifier	29c. License number D - 2.76	50	29d. Date signed (Mon	n, Day, Year) 7		
)	15		Account			6/2/0	<i>'</i>		
	1-		30. Name and address of person with completed cause of death (Item 23a) (Type Alpana Goswami MD 11125 Rockville Pi	ke Suite 110 / Ro	ckvilla	MD 20852			
			31. Date filed (Month, Day, Year) 32. Degistrar's Signature	INC DUICE IIU / NO	CVATTE?	TID 20032			
	Sta Registr		SILDate filed (world, bay, real)	male)					

DHMH 17 Rev 1/2001

07-04185 Darryl Anderson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	1- For State Certific Registrar	ate of Death	Reg. No.	2007 1231				
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Darryl Anderson	7	2. Date of Death Month Day June 1, 2007	Year 3. Time of Death 1916 hrs				
Mind	4a. Facility Name (if not institution, give street and number) 2513 Olson Street	4b. City, Town, or Location of Dec	F	c. County of Death Prince George's				
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birt 216–13–2388 1.XXM 2 F 32		8. Date of Birth(MM February 5,	/DD/YYYY) 9. Birthplace (State or Foreign Country) Wash. DC				
nd show any ice.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town Maryland Prince George's Oxon H			10d. Inside City Limits 1 Yes 2 XX No				
with the Maryland ms 23a or 28a-f show be uotified at once. eral Director	10e. Street and Number 1235 Southview Drive #201	10f. Zip Code 20745	10g. Cit	izen of What Country? USA				
fter death r, or iter er must y Fune	11. Marital Status 1 Never Married 2 XX Married 1 Never Married 2 XX Married 3 Widowed 4 Divorced If Yes 2 X No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 1 Yes 2 XX No specify:	rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black				
5-0036 led within 72 hours a tygiene. other than "natura in Medical Exami		Decedent's Usual Occupation (Give kind during most of working life. DO NOT use Recycling Technician	retired)	Kind of Business/Industry Recycling				
e, MD 21215-0036 I and 2 should be filed within 7 Health and Mental Hygiene. item 27 is marked other than r traumatic event, the Medica To Be Comple	17. Father's Name (First, Middle, Last) Alan G. Anderson	Jacq	me (First, Middle, Maider ueline A.	Young				
e, MD 21 i and 2 should Health and Me item 27 is ma r traumatic ev	Alan G. Anderson / Father 10	b. Mailing Address (Street and Number 0309 Marlboro Woods Driv	e Cheltenham,	Maryland 20623				
Baltimore, M pemit Pages I and 2 Department of Health. Important: If item 2 injury or other traum	1 XX Bunal 2 Cremation 3 Removal from State crema 4 Donation 5 Other Specify:	,	11/07	Suitland, Maryland				
Balt permit Depart Impor injury	21. Sig re of Funeral Service Licensee	22. Name and Address of Facility (Oxon HIII, Mar	yland 20743				
Physician /Medical xaminer	art I. Enter the disease, or complications that caused the death. Do n failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Gunshot Wounds Council Due to (or as a consequence of):		ac or respiratory arrest, sh	Approximate Interval Between Onset and Death				
led Insit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	= ,						
760, icate be executed physician and the burial - transit	d. UNPENDED AMENDED							
ox 68 ath certif attending or use as	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day							
ires that the decision signed by the a detected for the decision of the analysis and by Physes		ng in the underlying cause given in Part I.		o use contribute to the cause of death? No 3 Probably 4 Unknown				
tal Records, lian: The law requires certificate has been sig ector, page 2 should bb Be Completed			24a. Was an autopsy performed?					
tal R clan: T certifica rector, pa	25. Was case referred to medical examiner?	26.Place of Death (Che		dence 6 ✔ Other: Scene				
on of Vital Rec nding Physician: The I th. r: After this certificate I te funeral director, page tion: To Be Con	1 Yes 2 No Impatent 2 Live	Outpatient 3 DOA Care 4 Nu. Time of Injury 28c. Injury at Work? 1 Yes 2 ✓ No	28d. Describe how in Subject was sho	njury occurred				
Division o To the Hospital or Attending within 24 hours effer death. To the Funeral Director: Aff completely file, in by the fune edical Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Woods	farm, street, factory, office building, etc.		and Number or Rural Route Number, City Temple Hills, MD				
To the Host within 24 hd To the Funn completely 1		eath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cause(s) a ed at the time, date and p	and manner as stated. blace, and due to the cause(s)				
Merse	Sant Routhallim	29c. License number O.C.M.E.		ne 2, 2007				
NE (6)	38 Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examine		e, MD 21201					
State Registra		K)						

DHMH 17 Rev 1/2001 OCME 2006

07-04483

Robert Walter Barr	nes	Sta	te of Marylar								indic.		
•		For State		(Certificate	e of Dea	ath				g. No.		
Physician/		. Decedent's Name (First, Middle,						į.		2. Date of Death Month June 11, 2			Time of Death 2050 hrs
Medical Examine		Robert [la. Facility Name (if not institution,	Walter		Barnes	T 4b. City	, Town, or L	ocation of	Death	June 11, 2	4c. County of	of Death	
1		323 Popular Hill Avenue	-	b 01)		1	isbury				Wicomic	O	
Funeral		5. Social Security Number 6	i. Sex 7	. Age (In y	yrs. last birthda	ay) If U	nder 1 Year	If Under		8. Date of Birt	h (MM/DD/YYYY		lace (State or
Director	١	215-92-1998	1 X M 2 F	28		Yrs. Mor	nths Days	Hours	Min.	01/26	/1979	Foreign Cou n	Maryland
(b. \$4,641, %	_	Jsual Residence of Decedent										1	0d. Inside City Limits
w any	Т	10a. State 10b. County		10c.	City, Town or								Yes 2 No
yland yland Lonce.	5	Maryland Wicol	mico		Salisb		Zip Code			110	og. Citizen of Wh		•
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 83a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Finneral Director		323 Poplar Hi	ll Ave.			21801 USA						,	
vith th	- 1	11. Marital Status	12. Was Dece	dent Ever	in U.S. 1	3. Was Dece	edent of Hisp	anic Origin	n? (Sp e	ecify Yes or No-	14. Race		n Indian, Black,
r death with or items 23	<u> </u>	1 XNever Married 2 Mar	ried Armed For	ces?	No.	If Yes, spe	ecify Cuban,	Mexican, I	Puerto F	Rican, etc.)	White	a, etc.	
s after d		3 Widowed 4 Divo	rced If Yes, Give Year			1 Yes					Specify:		nite
nours a xami	֡֟֝֟֝֞֓֞֓֟֟֝֓֓֓֓֟֟֝֓֓֓֟֟֝֓֓֓֟֟֟	15. Decedent's Education (Speci			ed) 16a. De dui	cedent's Usu	ual Occupation	on (Give ki DO NOT u	ind of w	ork done ed)	16b. Kind of Bu	siness/Ind	lustry
16 n 72 h nan "r ical E		Elementary/Secondary (0-12)	College (1-	4 or 5+)	Шо	ahn i a i					Поки	~~ C.	abool
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exam	<u> </u>	9 17. Father's Name (First, Middle, I	ast)		1 Te	chnici		8.Mother's	Name	(First, Middle, M	Harva: Maiden Surname		11001
215- be filed mal Hy rked of ent, the		George Jackson						Ter	esa	Amanda	Barnes		
212 ould b d Ment is ever	o 🗀	19a. Informant's Name/Relationsh			19b. I	Mailing Addr	ess (Street	and Numb	er or R	ural Route Nun	nber, City or Tow	n, State, Z	Zip Code)
MD 12 shc th and 1.27 is umati		Teresa B. Gree	nlee/moth						, S		y, MD 2	1801	
Te, land Heal	ſ	20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal fro	1	20b. Place of I crematory	Disposition (I y or other pla		·		Date	20c. Location	•	
Pages nent of		4 Donation 5 Other Spe			Salisb					5/07	Salis		
talti rmit. epartn a port	1	22. Name and Address of Facility HOLLOWY Funeral Home Professional A									ssociation		
	4	David H. W.	mmo (CFSf	doath Donot	I DOT	Snow	HITT	Ka.	, Salis	soury, M	D STC	Approximate Interval
Physician /Medical	1	failure. List only one cause of	Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart									Between Onset and Death	
Examiner	1	Immediate Cause (Final disease or condition resulting in death)	a. Hyperten Due to (or as a			scular	uisease						
		Sequentially list conditions,	b									-	
		if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	conseque	ence of):								
	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	conseque	ence of):								
			d										
ial ial		XUNPENDED	A#ENDED	I,27,	perME, G	868 <u>,</u> 6/	21/07 T	Τ			Lond Date	£ delices	
Box 68760 e death certificate b the attending physi ed for use as the bu	cian/Medical	IF FEMALE: 23b. Was decedent pregnant in the	e 23c. If yes, o		f pregnancy	Fetal de	ath 3	Ectopic	pregna	incy	23d. Date of Month	Da	ay Year
x 68 h certi tendin use a		past 12 months?	4 Pregna	ant at time	e of death 5	Other (Specify)				1		
Bo ne deat the at	Phys		nown g Unkno		t - et secultion	in the under	vina cousa s	ivon in Da	rt I	23e Did t	obacco use conf	ribute to th	ne cause of death?
P.O. es that the gened by be detach	Š	Part II. Other significant conditi Obesity; hepa		deam bu	t not resulting	in the under	ying cause g	giverinira					ably 4 🗸 Unknown
duires	ted	Obesity, nepa	<u> </u>							24a. Was		Were auto	opsy findings available
Division of Vital Records, tal or Attending Physician: The law requints after death. The Institute of the this certificate has been so an Director: After this certificate has been so the funeral director, page 2 should be the funeral director, page 2 should be a should	Completed		_ 			-					ormed?	death?	ompletion of cause of
Ref	ខ្ញុំ	05 M					26 Place	of Death	(Check		2 No	1 Yes	2 No
irecto	a B	25. Was case referred to medical examiner?	11	npatient	2 ER/Out	patient 3		Other4		ng Home 5	Residence 6	✓ Other:	Scene
of V g Phy frer th	잂	1 Yes 2 No 27. Manner of Death	28a, Date		28b. Ti	me of Injury	28c. Inju	ry at Work	?	28d. Describe	how injury occu	rred	
on on endin ath.	힐	1 X Natural 5 Pend	ling	, Day, 19ai)			1 ,	Yes 2	No				
VISI or Att fter de Directe	ig E		d not be 28e. Place	e of Injury	- At home, far	m, street, fac	ctory, office t	ouilding, et	c.	28f. Location or Town,		ber or Rur	al Route Number, City
Divisior Spital or Attend nous after death noral prector: y filled in by the	Certification:	4 Homicide deter	mined (Specify)										
		29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example 1	nysician: To the bes	it of my kn	nowledge, deat	h occurred a vestigation, i	at the time, da in my opinion	ate and pla n. death oc	curred	due to the cau at the time, date	ise(s) and manno e and place, and	er as state due to the	d. e cause(s)
To th Your Comp	Medical	29b. Signature and title of certifie	and manner s	tated.			29c. Licens						th, Day, Year)
	_	255. Signature and title of certifie	o NA	8 0	On.	^	O.C.				June 12,		
		30. Name and address of person	who completed caus	se of deat	h (Item 23a)								
j			sistant Medical			enn Stre	et, Baltim	ore, MD	2120)1			
Sta	ite		5 2007 ^{32. R}	distrar's	Signature	lovele)							
Registr	ar	Registrar JUN 13 2007 Registrar											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician Tune 200 Yvonne Arlene Brittingham /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner aston Memoria If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months 1 ☐ M 2 🕱 F 212-78-9347 Director Mar 7, 1960 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Director MD Worcester Berlin 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21811 USA 121 Branch St. by Funeral permit. Pages 1 and 2 should be filed within 72 hours after dean Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural". or the any injury or other traumatic event. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 XNever Married 2 Married Black 1 ☐ Yes 2 ☐ Mo Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Custodian Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eleanor Sturgis Benjamin F. Brittingham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7406 Maury Rd., Baltimore, MD 21244 Shawn R. Brittingham 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □Removal from State 4 Donation 5 Dother (Specify) 6/8/2007 Paul's Cemetery Berlin, MD 22. Name and Address of Facility 21. Signature of Eumeral Service Ligantee Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) Physician Se /Medical (or as a consequence of): Due to Examiner mmose Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) 2 No P.0. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes Be Completed

Records, page 2 should certificate has **Division or Vital** director, this funeral After the Hospital or Attending n 24 hours after death.

The Funeral Director; Af Sietely filled in by the fun

23e. Did tobacco use contribute to the cause of death? 2XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2/2 No 25. Was ca e referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 200 No 2 ER/Outpatient 3 DOA 1 Tes Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

1 Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical the 0

Certification: To

29a, Certifier

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 219 S. Wash Monte no

State Registrar 31. Date filed (Month, Day, Year) JUN 07 2007 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** JUNE GINA FAY BEST 2007 8:58 AM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES SOUTHERN MARYLAND HOSPITAL CENTER CLINTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, JUNE 4, 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1□M 2₩F WASHINGTON, D.C. 1961 46 220-80-3002 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show a notified at show 1 ¥Yes 2 ☐ No WHITE PLAINS Directo MARYLAND **CHARLES** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r Items 23a or 2 UNITED STATES 20695 10525 CATALINA PLACE by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 3 YEARS LEGAL INDUSTRY ADMINISTRATIVE ASSISTANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY MADGLINE FAISON BEST GEORGE BEST 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11400 PLENTY GATES COURT, WALDORF, MARYLAND 20601 SHIRLEY MILTON / FRIEND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State RESURRECTION CEMETERY JUNE 11,2007 CLINTON, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNTON JOHNSON MOO583 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. nut enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Unline Physician /Medical Due to (or as a consequenc) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or us a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 □ Yes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21-No 2 ER/Outpatient 3 DOA 1 Japatient this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: (Month, Day 1 Anatural 5 Pending investigation 1 ☐ Yes 2 No after death.

Director: / 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and completed cause of death (Item 23a) (Type, Print) address of person with 2001

DHMH 17 Rev 1/2001

State Registrar th, Day, Year

31. Date filed (Month

07-04205

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	State of Maryland / Department of Health and Mental Hygi 1-For State Certificate of Death	Reg. No.	2007 1985						
Physician/	1. Decedent's Name (1 list, Middle, Last)	Date of Death Month Day	3. Time of Death Year 1327 hrs						
ledical Examiner		une 2, 2007	County of Death						
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Doctors Community Hospital Lanham		rince George's						
Funeral Director	o. codici coccini) i conce	Date of Birth (MM/I July 15,1	962 Signification of Society Profession of Profession of Society Profession of Profession of Profession of Profession of Profession						
×	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits						
d now any	Maryland Prince Georges Lanham		1 X Yes 2 No						
the Maryland a or 28a-f show tified at once. Director	10e. Street and Number 10f. Zip Code	10g. Citiz	zen of What Country?						
with the Maryland ns 23a or 28a-f sho to notified at once, eral Director	7004 Innsfield Court 20706		ited States						
hours after death with the Maryland Examiner. or items 23a or 28a-f sho Examiner must be notified at once ted by Funeral Director	11. Marital Status 1 Never Married 2 X Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ric		 Race - American Indian, Black, White, etc. 						
fter dea	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify: Black						
ours after attural" xamine	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work during most of working life. DO NOT use retired	,	Kind of Business/Industry						
16 n 72 h nan "n ical E	Elementary/Secondary (0-12) College (1-4 or 5+) 4 years IT Manager	50	outheastern niversity						
5-0036 led within 72 hours a 'tygiene. other than "natural the Medical Examin Completed by	17. Father's Name (First, Middle, Last) 18. Mother's Name (Fi								
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica FO BE COMPIE		losetta I							
	19a. Informant's Name/Relationship (Type, Print) Jerome Dewaine Barbour (Husband) 19b. Mailing Address (Street and Number or Rura 2/18								
and 2 sho and 2 sho ealth and tem 27 is traumati	ZUA. MELLIOU OI DISPOSITION		Location - City or Town, State						
nore ages 1 nt of H it: If i	1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Population 5 Other Specify: 4 Population 5 Other Specify: 4 Population 5 Other Specify: 5 Other Specify:	7,2007 V	Washington, D.C.						
Baltimore, permit. Pages 1 an Department of Hea Important: Titer injury or other tri	4 Donation 5 Other Specify: Grenwood Cemetery Suffer Signature of Funeral Project Licensee 22. Name and Address of Facility R. N. Horton Company								
W F P F F	Oxagolde h & Market 600 Kennedy Street.	N.W.:Wasl	nington,DC.20011						
Physician local	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or refailure. List only one cause on each line.	espiratory arrest, sno	Between Onset and Death						
caminer	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):								
	Sequentially list conditions, b								
ed nsit Exa mine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated c.		-9						
sd ssit	events resulting in death) Last Due to (or as a consequence of):								
'60, ate be execute physician and ne burial - tra	d. UNPENDED AMENDED								
60, ate be shysicia e buria	IF FEMALE: 23c. If yes, outcome of pregnancy	23	d. Date of delivery						
687 certific ding p	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnanc	y	Month Day Year						
b. Box 687. The death certific the death certific by the attending I ched for use as the	1 ☐ Yes 2 ☐ No 9 ✔ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (Specify) ☐ Unknown								
Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be executed its after death. al Director: After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - transil ertification: To Be Completed by Physician/Medical Exertification: To Be Completed by Physician/Medical Exertification:	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown						
S, P luires t an sign ild be d		24a. Was an	24b. Were autopsy findings available						
Records, The law requires ficate has been sig page 2 should be Completed		autopsy performed?	prior to completion of cause of death?						
Rec The ficate 7. Page Con	25. Was case referred to medical 26.Place of Death (Check on	· · · · · · · · · · · · · · · · · · ·	No 1 ✓ Yes 2 No						
Vital ysician his cert directo	aversipor?		ence 6 Other:						
ivision of Vital I or Attending Physician: ther death. Director: After this certifi Lin by the funeral director, tification: To Be C	27 Manner of Death 28a Date of Injury 28b. Time of Injury 28c. Injury at Work? 28	8d. Describe how in	jury occurred						
Division o spital or Attending tours after death. neral Director: Aft filled in by the fune Certification:	1 Natural 5 Pending 2 Accident Investigation	06 1	and Alumbar on Durel Pouts Alumbar City						
Divis al or A safter al Dire	3 Sulcide 6 Could not be determined (Specify)	or Town, State)	and Number or Rural Route Number, City						
Q Fig 6 8	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and discovered at the time, date and place, and discovered at the time.	ue to the cause(s) a	nd manner as stated.						
Division of Note the Hospital or Attending Physician 24 hours after death. To the Funeral Director: After the Completely filled in by the funeral Medical Certification: The Complete of The	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at t and manner stated.	he time, date and p	lace, and due to the cause(s)						
E » E 8	29b. Signature and title of certifier 29c. License number	1	. Date signed (Month, Day, Year)						
	Carol Hall (1) O.C.M.E.	Jui	ne 3, 2007 						
10 /23/	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
State	100 Designate Signature								
Registra									

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month Mattie Eva Becton June 2007 7:05 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ft Washington

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 2600 Rose Lane Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Months 1 □ M 2 □XF Yrs. Director 416-68-4265 58 Aug. 6, 1948 Alabama Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ms 23a or 28a-f shov 11 Yes 2 □ No Maryland Prince George's Washington Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2600 Rose Lane 20744 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced naturel American in than "nature Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental Henry Mitchell, Sr. Mattie Eva Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Charles B. Becton, Jr./Son 9312 Walden Brook Drive, Lithonia, GA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 6/8/2007 Landover, MD 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licensee 4001 Benning Rd., NE Wash., DC 20019 23a. Part1 Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cancer LUNG yean /Medical Due to (or as a correquence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisaase or what) that initiated events resulting in death) Last Due to (or as a consequence of): physicien and the burial-transit To the Hospitet or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) .O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 X No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 📉 No this After this funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation s after de. 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 085365 06-02-2007

R (5)

State 31. Date filed (Month, Day, Year) JUN 0 7 2007

SiDAROUS M.D 11701 livings ton NO #101, for washington MD 2074,
Year) 32. Registrar's Signature.

OT Security.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene

		•	State Registrar				C	ertificat	e of L	Death			Reg. N	vo. 2 0	07.	i	333
		14	1. Decedent's Name (First	st, Middle, Las	t)							2. Date of)av	Voor	3. Time o	of Death
			Anna I	[sabell	e	Brown	noltz									10:	10 ^{a M}
100		-						4b. City,	Town, or	r Location of	of Death						
*	LAGIIII		3405 St. I	Leonard	's Cou	rt		s	ilve	r Spr	ina				Мс	ntgon	nery
	Funeral						rs. last birthda	y) If Under	r 1 Year	If Under	24 Hrs.	8. Date of	Birth	25)	9. Birthp	lace (State	
н			160-03-4014	4 1	_ M 2 √ _ F	90	Yrs.	Months	Days	Hours						.,	
-abite	the wife on the																
	yland at		10a. State 10b.	. County		10c.	City, Town or	Location							1		
	Mar fied	ţo	Maryland	Monta	omerv		Si	lver S	prin	a						1 ☐ Yes	; 2 No
	r 28a	irec	10e. Street and Number		J 2 j					J			10g. (Citizen of W	hat Cour	itry?	
	3a o		3405 St.	Leonar	d's Co	urt			209	06				USA			
	ms 2	Jer	11. Marital Status		12. Was Dec	edent Ever in	U.S. 13	3. Was Dece	dent of H	lispanic Ori	igin? (Spe	ecify Yes or	No-				
ιO	after or ite		1 Never Married	2□ Married								nican, etc.)					
8	al", c	þ	3 🖳 Widowed 4 🗆	Divorced	Year or I	ates:		I LL Tes	ZISKINO	<i>Specity.</i>				Specify:	wnit	e.e	
9	72 hc	ted	15. I	Decedent's Ed	ucation		16a. Dec	cedent's Usu	al Occup	ation	at of worki	ina	16b.	Kind of Bus	siness/Ind	dustry	
21	thin an "I	adr.					life	. DO NOT u	se retired	1)		9					
21	d wi	5	12				Home	emaker									
pu	2 2 2 2 c		17. Father's Name (First	, Middle, Last)						18. Mothe	er's Name	(First, Mide	dle, Maid	len Surname))		
<u> a</u>	Ment Ment arkec		John Thoma	as McMe	nomy						Anna	Jane	Lut	ze			
an	and I		19a. Informant's Name/I	Relationship (7	ype. Print)		19b. Ma	iling Address	s (Street	and Numb	er or Rur	al Route Nu	mber, Cit	y or Town, S	State, Zip	Code)	
	and 2 salth 127 I		Bobbie Walk	cer/Dau	ahter		809	0rch	ard_	Way.	Silv	er Sp	ring	MD 2	20904	1	
ore	permit. Pages 1 a Department of Hee Important: If item any injury or othe				D	I .	 Place of Dis 	position (Na	me of	- 1	. [Date	20c.	Location - (City or To	wn, State	
Ĕ							ate of	Heave	n Ce	meter	y 2	007	Si	lver S	sprir	ng, Mar	ryland
alti	mit. partn borta / inju		21. Signature of Funera	l Service Licen	see	**	1	22. Name a	nd Addre	ss of Facili	ty ns	Funer	al H	ome Ir	1C.		
m	e a H De		Ago	2 44	()	-Qu	1.0									.MD 2	20901
			23a. Part1, Enter the dis	sease, or comp	olications that	caused the	ath. Do not	enter the mo	de of dyin	ng, such as	cardiac (or respirator	y arrest,		7	Approxima	ate
## Sabe 12 Powerholtz ## Sabe 12 Powerhol	Onset and	Death															
								ase	-	Month May 31 2007 10:10 a M							
	Examiner				_								4c. County of Death Montgomery				
- 4		je l	Sequentially list condition if any, leading to immed	ons, liate		(or as a cons	equence of):	Ab. City, Torw, or Location of Death Silver Spring									
	uted d ansit	Ē	Cause (Disease or injury that initiated events		C												
o,	exec	Exa	resulting in death) Last		Due to	(or as a cons	equence of):										
92	te be ysicia ie bu	cal			.d												
89	tifica ig ph as th	led												I			
	h cer endir use	~		gnant				3 □Ectopic n	ronnancı	v				į.		-	
	death e atte	icia			4□Preg	nant at time o				y 			_	Mor	ıth	Day	Year
0	t the	hys			911Unk	nown											
	s tha		Part II. Other significan	t conditions o	ontributing to	death but not	resulting in the	underlying	cause giv	en in Part	l.	23e. D	id tobacc	o use contri	bute to th	ne cause of	death?
Ď	quire in sig uld b	D D										1	☐ Yes	2¥⊡ No	3 🗌 Prob	ably 4]Unknown
00	s bee	ete															
Re	he la e has	ᇤ					-					p p	erformed	? d	leath?	•	cause of
a			25 Was case referred to	o medical						26 Place	a of Deat			No I	LI Yes		
5	sicia cert irect		examiner?	o modiedi	Hospital:	Innationt 2	□ FB/Outnat	ient 3 🗆 D	Oth	or.				s ClOtha	or (Specif	5/)	
o	Phy er this eral d				28a. Date	of Injury	28b. Time	e of								<u>y)</u>	
on	ding h. Afte fune	tior		☐ Pending investigation		nth, Day Year) Injur				No						
S	Atter deal ctor	fica	3 ☐ Suicide 6		Zoe. Plac	e of injury - A	t home, farm,	street, factor	y, office			28f. Locatio	n (Street	and Numbe	er or Rura	al Route Nu	mber,
Ö	after Dire	ert	4 Homicide	determined	buil	ding, etc. (Spe	ecity)					City or	Town, St	tate)			
	spita lours neral																
	e Ho 24 h	dic	(Check only 2 one)	Medical Exar			ination and/o	r investigatio	n, in my o	opinion, de	ath occur	red at the tir	ne, date	and place, a	ınd due t	o the cause	(s)
	oth vithin oth comp	Me	29b. Signature and title	of certifier	2 1	//	1	29	c. Licens	se number			29d.	Date signed	(Month,	Day, Year)	
N			> M1	1600	11/	Tran	les		D	15901				June	4, 2	2007	
	10		30. Name and address	of person who	completed car	ise of death	tem 23a) (Tvr	e, Print)				10.					
							,		ue,	#114W	, Wa	shing	ton,	DC 20	016		
	Sta	ate			/63	Registrar's Si	gnature	1 .5	es,								
	Regist		JUN	0 5 20	07	Muse	S. A	DECE!									

DHMH 17 Rev 1/2001

ORIGINAL

Pages 1 and 2 should be filed within 72 hours after death with the Maryland 'natural', or items 23a or 28a-f show oical Examiner must be notified at Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

Physician /Medical Examiner

Division or Vital Records, P.O. Box 68760,

9	17060 King Jame	s Way #114		20877	Guatema]	temala		
DIID.	11. Marital Status 12 Married 2 Married 12	2. Was Decedent Ever in U.S. Armed Forces? 1		as Decedent of Hispanic O Yes, specify Cuban, Mexica		o- 14. Race - Ame Black, Whi		
2	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	12	[©] Yes 2□No G ^{Specif}	emalan	Specify:	White	
בונו	15. Decedent's Educa (Specify only highest grade	completed)	(Giva ki	nt's Usual Occupation ind of work done during mo	est of working	16b. Kind of Business	/Industry	
completed by	Elementary/Secondary (0-12)	College (1-4or 5+) [5]	Direc Symph	tor of Nat ony Orches	tra Guate	mala	Music	
3	17. Father's Name (First, Middle, Last) Jose Barrientos	Morrono		18. Moth	ner's Name (First, Middle			
2					Ernestina			
	19a. Informant's Name/Relationship (Type			Address (Street and Numi				
	Betty Barrientos 20a. Method of Disposition			0 King Jam	es Way #1	14 Gaither		
	1 XBurial 2 □ Cremation 3 X Re 4 □ Donation 5 □ Other (<i>Specify</i>)	moval from State Gen	etery, crema	Cemetery		Guatemal Guatemal	la City,	
	21. Signature of Funeral Service Liganore	R		TTTF AGERTA 41 Columbia				
	23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	ations that caused the death. I	Do not enter	the mode of dying, such a	s cardiac or respiratory	arrest,	Approximate Interval Between	
	Immediate Cause (Final disease or condition	Cerebrovas					Onset and Death	
	resulting in death)	Due to (or as a consequen	nce of):					
2	Sequentially list conditions, if any, leading to immediate cause. E. iter Unionying Cause (Disease or injury	Due to (or as a consequen	nce of);					
3	that initiated events resulting in death) Last	Due to (or as a consequen	oce of):					
j	d.	Due to (or as a consequen						
3	IF FEMALE:						<u> </u>	
	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	 c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal deal 4 □ Pregnant at time of deal 9 □ Unknown 	eath 3⊟E	Ectopic pregnancy Other <i>(specify)</i>		23d. Date of de Month	elivery Day Year	
	Part II. Other significant conditions conti	ributing to death but not resultir	ng in the und	lerlying cause given in Part	I. 23e. Did	tobacco use contribute t	o the cause of death?	
200					1	Yes 2□No 3□P	robably 4 XUnknown	
and and					24a. Was autc perl 1∐ Yes		utopsy findings available completion of cause of s 2 No	
3	25. Was case referred to medical examiner?				ce of Death (Check only	one)		
2	1 163 2 110	ospital: 1 ☐ Inpatient 2 ☐ ER				sidence 6 AOther (Spe	ecify) hospice_	
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	3b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 [how injury occurred		
200	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home building, etc. (Specify)	e, farm, stree	et, factory, office	28f. Location City or To	(Street and Number or Rown, State)	lural Route Number,	
200		clan: To the best of my knowle er: On the basis of examination and manner stated.						
7	29b. Signature and title of certifier wh	older un		29c. License number D006461		June 4,		
	30. Name and address of person who com		3a) (Type, P		ator Mill	Pd Pocks		

State

Registrar

31. Date filed (Month, Day, Year)

JUN

05

2007

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrat Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Physician \mathbf{P}^M June 1, 2007 1:28 Jusouida Melva Smith Brown /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Crescent City Center Riverdale Prince Georges If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 1 □ F 76 July 21. 1930 Washington, D.C. Director 578-64-6954 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director MN Dakota Burnsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. 13900 County Road #5 55337 U.S. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: Completed by 3 X Widowed 4 ☐ Divorced American 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Caesar Smith Birdie Cotton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health em 27 I 991 Cass Street, Monterey, CA 93940 Michelle P. Brown, M.D. / Daughter Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If its any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State June 9, 2007Minneapolis, MN 4 ☐ Donation 5 ☐ Other (Specify) Lakewood Cemetery 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licensee Undre 20012 7400 Georgia Ave., N.W. Washington, D.C. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Creutzfeldt-Jakob Disease 9 Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. E. Ref. Urdellying Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed ician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Dav Year 4∏Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1

Yes 2 □ No 24a. Was an this certificate 1X Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA 2**X** No 1 ☐ Yes 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury 28h. Time of 28c. Injury at Work? 28d Describe how injury occurred After (Month, Day Year) Division or Attending 5 Pending investigation 1 X Natural in 24 hours after control the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide Hospital 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D01852 June 4, 2007 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hyattsville, MD 20871 4203 Queensburg Rd. DeVore, M.D. Paul A. Registrar's Signature 31. Date filed (Month, Day, Year) State 2007

DHMH 17 Rev 1/2001

Registrar

JUN

05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MATTHEW ALAN BEAN MAY 31 2007 4:20 A^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 MA 3/15/85 Year) 1XM 2□ F Months Days Hours Min. 025-66-9209 22 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MA Plymouth 1 X Yes 2 □ No Pembroke 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 Fairway Lane 02359 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ⊠ Yes 2 □ No
If Yes, Give 2007
Year or Dates: 1 XNever Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Soldier US Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dana Alan Bean Mary H. Brennan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dana A. Bean/Father 16 Fairway Lane Pembroke, MA 02359 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ★ Burial 2 Cremation 3 Removal from State Pembroke Centre Cem. 6/8/07 4 ☐ Donation 5 ☐ Other (Specify) Pembroke, MA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility
Murphy Funeral Home 4510 Wilson Blvd. Ari., VA Jack C. Mascubles 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CRANIOCEREBRAL INJURIES Due to (or as a conseque Sequentially list conditions, any, leading to infraedate cause. Enter Underlying Cause (Disease or injury Due to (or as a consuquence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 XYes 2 No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 ☐ No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation MAY 19 2007 10:14AM 2 Accident DURING MILITARY OPERATIONS 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) LUTIFIYAH IRAQ

The law requires that the death certificate be executed burial-transit and Division of Vital Records, P.O. Box 68760. physiciar the as use jo ed by the a detached f signed to 2 should has page certificate or Attending Physician: funeral director, s after death. the in by t filled

Physician/Medical Completed by Be Certification: To Medical

4 X Homicide

29b. Signature and title of certifier

JUN 0 8 2007

ELIZABETH A. ROUSE

29a. Certifier (Check only one)

Examiner

Physician

/Medical

Examiner

Funeral

Director

or 28e-f show

Directo

Funeral

ģ

Completed

Be

r then "neturel", or items 23s or 28e-f showing Medical Examiner shall be notified at

ō

and Mental Hygiene.

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
eny injury or other trau

Physician

Examiner

/Medical

hours after

å

Pages 1 and 2 should nent of Health and Men

Baltimore, Maryland 21215-0036

within 24 hours a To the

State Registrar

31. Date filed (Month, Day, Year)

determined

32. Registrar's Signature

MC

and manner stated.

(my)

 ${\sf LtCol}$

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BATTLEFIELD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

0101054497 (VA)

ROCKVILLE MD 20850

29d. Date signed (Month, Day, Year)

May 31,2007

ARMED FORCES INSTITUTE OF PATHOLOGY

DHMH 17 Rev 1/2001

USAF

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 29 2007 7:50 A M May Louise K. Brodnax /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Suitland 2606 Fort Drive Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, If Under 1 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□ M 20XF Yrs. June 16, Wash., 72 Director 579-46-2679 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show event, the Medical Examiner must be notified at 1X Yes 2 □ No Prince George's Suitland Maryland Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2606 or Itams 23a or United States 20746 Fort Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Amed Forces? 11 Marital Status Black, White, etc. African filed within 72 hours efter 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ American 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: if Item 27 is marked other the eny Injury or other traumatic event, Item 2006. Social Work Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Geneva Baxter David Kelley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3629 Minnesota Ave., SE Wash., DC 20019 Shirley Alston/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Resurrection Cemetery | June 5, 2007 Clinton, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licurs Name and Address of Facility Stewart Funeral Home Wash., DC 20019 4001 Benning Rd., NE Approximate Interval Between Onset and Death 23a. Part1 Ener the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** Dra resulting in death) /Medical Due to (or as a consequence of) Examiner Resec Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. by Physician/Medical IF FEMALE: NA 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 DUnknown Š 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 D No 3 ☐ Probably 4 ☐ Unknown Completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to impletion of cause of death? 24a. Was an certificete has autopsy performed? 2□ No 2□No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check-only one) Hospital: 1 ☐ Inpatient Other: 4 \(\sum \) Nursing Home 5 Sesidence 6 ☐ Other (Specify) 1 ☐ Yes 2 ₽ No Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 Pending investigation 1 V Natural _ M 1 ☐ Yes 2 ☐ No death 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 6.5.2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CLINTON, MD. 26735 CHANDRA PISCATAWAY

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2007

32. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Anna Marie Brower 0315AM MAY 28 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Glow Burme Anne Arundo Baltimore WAXHIMYTON Medical Conten 8. Date of Birth (Month, Day, Year)
Aug. 31, 1928 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days 1 □ M 2 🛣 F 78 Director 220-20-2265 Usual Residence of Decedent 10d. Inside City Limits 10a State 10h. County 10c. City, Town or Location 1 ☐ Yes 🙀 ☐ No Anne Arundel Severna Park Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21146 533 Kenmore Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married White 1 ☐ Yes 2 No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker **Home** 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental I Important if Item 27 is mediany Injury or other Charles McQuaid Ella Tarlton ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 533 Kenmore Road, Severna Park, MD 21146
Disposition (Name of Date 20c. Location - City or Town, State William J. Brower, Jr./Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Jun. 1, 2007 1⊠Burial 2 □Cremation 3 □Removal from Crownsville, MD MD Veterans Cemetery 4 □ Donation 5 □ Other (Specify) gnature I uneral Service Icenses Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. Approximate Interval Between Onset and Death 3a P art1. Enter the disease, or comp shock, or he in failure. List only nmediate Cav (Final lisease or condition esulting indeath) Failure Physician /Medical Due to (or as a consequence of): Examiner Pi A betcs Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury) Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🟋 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

completely filled in by the Hospital 24 hours a within 2 To the

with the Maryland

death \

V

Sre w

ould be filed within 72 hours after Mental Hygiene.

death certificate be executed

Division or Vital Records, P.O. Box 68760,

burial-trar and

the as

use

detached þ

В

page 2 s

funeral director,

certificate Physician:

this

death. after death

ō

physician

Baltimore, Maryland 21215-0036

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

State Registrar

31. Date filed (Month, Day, JUN 0 1 2007

29b. Signature and title of certifier

Henry

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAHIMORC MP

WASHING TON MeliCAI (renter

29c. License number

1)027415

29d. Date signed (Month, Day, Year)

		4	For State of Maryland / D State of Maryland / D Registrar		tment of He <i>ificate of D</i>			giene Reg. No. (2007	19859	
۳	Dhaminia		Decedent's Name (First, Middle, Last)				2. Date of Dea Month	ath Day	Year	3. Time of Death	
	Physicia /Medic	_	Stephanie Jernigan Baker				May	30	2007	01:52 P ^M	
)	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death				4c. County of Death			
100	<u> </u>	9	3355 Easton Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		Edgewater If Under 1 Year If Under 24 Hrs.		8. Date of Birt	Anne Arunde1 h			
	Funeral Director		4 D 11 o V 5	Yrs.	Months Days	Hours Min.	(Month, Da)	7, Year) 1950	Mai	ntry)	
tac			Usual Residence of Decedent							40.1.1.10	
	arylan show d at	Ē	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 🛣 No								
	Ba-f s	ecto	Maryland Anne Arundel Edgewater 10e Street and Number 10f, Zip Code 10g, Citizen of What Country?								
	with ti	<u>i</u>	10e. Street and Number 3355 Easton Road		10f. Zip Code 21037				ted Sta		
	ns 23 must	Funeral Director	12 Was Decedent Ever in U.S.	13. W	as Decedent of His Yes, specify Cuban	panic Origin? (Sp	ecify Yes or No		4. Race - Ameri	can Indian,	
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If the m Z1 is marked other than "natural" or items 23a or 28a-f show if if them Z1 is marked other than "natural" or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at	by Fun	1 Never Married 2 Married 1		Yes, specify Cuban □ Yes 2[X]No	Rican, etc.)		Black, White, etc. Specify: White			
5-0036	2 hou latura cal E		15. Decedent's Education 16a.	Decede	ent's Usual Occupat	ina	16b. Kind of Business/Industry				
212	ithin 7 ne. nan "n Medi	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ind of work done du O NOT use retired)	ing	Home					
_	e filed w al Hygier other th		12 Ho	omem	aker	18. Mother's Name	e (First Middle				
	ild be fi lental H ked of ic ever	Be o	Donald Jernigan Mary Elle								
	z snould be z and Mental ls marked (raumatic ev	은	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							ip Code)	
	ind 2 salth ar 27 ls 27 ls r trau	- 5		355	Easton Ro	ad. Edge	water.	Mary!	land 21	037	
	es 1 and; of Health fitem 27 rother tr	1	20a. Method of Disposition 20b. Place of		ition (Name of atory or other place		Date		ation - City or T		
Ē	Pages nent of int: If its iny or o		1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Kalas	_		1	3/2007	Edge	water,	Maryland	
Baltimore,	permit. Pages Department of Important: If it any injury or once.		21. Signature of Faragraphs Vice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037								
-			23a Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate								
	Physician	8 6	Immediate Cause (Final								
	/Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of):								
			Cognosticily liet conditions h.								
D	p #	iner	Sequentially list conditions, if any, leading to immediate caus. Every moderning Cause (Disease or injury	of):							
	ecute and -trans	Examiner	that illitated events	c							
60,	icate be executed physician and s the burial-transit										
98760		edical	d					1			
Box	leath certific attending p for use as t		IF FEMALE: 23b. Was decedent pregnant 1 □Live birth 2 □ Fetal death	ہ ⊐۔	Ectopic pregnancy			23d. Date of delivery			
	deatl	Physician/M	1 Yes 2 No 4 Pregnant at time of death	Other (specify)		Month Day Year		Day Year			
	at the	Phys	9 ☐ Unknown • 9☐ Olikilowii					23e. Did tobacco use contribute to the cause of death?			
	The law requires that the death certif te has been signed by the attending tage 2 should be detached for use a	ρχ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					1 Yes 2 No 3 Probably Unknown			
	law re as bee 2 sho	Completed					24a. Was an autopsy		24b. Were autopsy findings available prior to completion of cause of		
		Som						performed?		2 No	
	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner? 1 Yes 25 No								
	Physical this cral dir	. To									
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification in the funeral director, which is the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director director directors are the funeral director directors and the funeral director directors are the funeral directors and the funeral directors are the funeral directors and the funeral directors are the funeral directors and the funeral directors are the funeral directors and the funeral directors are the funeral directors are the funeral directors and the funeral directors are the funeral directors.	tion	27. Manner of Death 1 Molatural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28b. Time of Injury at Work? 1 Accident investigation 1 Pending (Month, Day Year) 1 Yes 2 No								
		Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, fa building, etc. (Specify)	eet, factory, office	ory, office 28f. Location (Street and Number or In City or Town, State)			Number or Ru	ral Route Number,		
_	fospital 4 hours a funeral I ely filled	edical Ce	29a. Certifier (Check only (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
	thin 2,	Medi	one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signature and title of certifier 29d. Date signature and title s					signed (Monti	n, Day, Year)		
	J W J		fanise wer MD		D52830			may 31, 2007			
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								
	12CH	CHI PRAVING WEINOR MO GID KISTGAR ROSE ISO, HWGASIS, MO 7/401									
J	State Registrar 31. Date filed (Month, Day, Year) 12007 32. Signature										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JOSEPHINE 05:25 4M JUN 2007 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Quiter Baltimore Merce Mede (ce) baltmire 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 200 F Months Days Hours 82 216-22-7593 Director Feb. 20, 1925 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any finjury or other traumatic event, the Medical Examination. 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 20℃ No Maryland Washington Hagerstown10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12155 Walnut Point West 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Yes 22 No Specify. white þ Specify: 3 Midowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry telephone Elementary/Secondary (0-12) 7.2 College (1-4or 5+) Manager's Clerk communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis Vernon Lewis Pauline Rebecca Engle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia Hutzell, POA 10831 Coffman Ave., Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hagerstown Crematory 6/7/07 Hagerstown, Maryland 4 ☐ Donation = 5 ☐ Other (Specify) 22. Name and Address of Facility MINNICH FUNERAL HOME of Funeral Service License 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death metastatic aranian cancer Immediate Cause (Final Physician 2 Moutes disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last physician ar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha autopsy perform death? 1 ☐ Yes 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be 1 Yes 2 No Other: 1☐mpatient 2☐ER/Outpatient 3☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident i Director: d in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours at To the Funeral C filled tire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar NAZARIAN

31. Date filed (Month, Day Year) -

BALTIMORS

301

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year :58 AM Physician VIRGINIA BRYAN MARY 2007 une /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 212-28-8181 76 September 28,1930 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ "" any injury or other traumatic events." 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21742 13120 Blue Ridge Road U.S.A. Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: White <u>م</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vowell Trussell Virginia Edward Mary Siefers ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13120 Blue Ridge Road, Hagerstown, Maryland 21742 Peter F. Bryan Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hagerstown Crematory 06-06-07 Hagerstown, Maryland 22. Name and Address of Facility
Andrew K. Coffman Funeral Home, Inc.
40 East Antietam Street, Hagerstown, 21. Signature of Funeral Service Licensee R. hoel. Braa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hemorhas **Physician** Intracrania disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transi Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregpant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification:

Records, P.O. Box 68760. Division or Vital To the Hospital or Attending Physician: After this death. within 24 hours after death To the Funeral Director:

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only

COH-4

State Registrar decellet.

5 Pending investigation

6 Could not be determined

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

H006 1117

1 ☐ Yes 2 ☐ No

Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 (meds DD

EasT Hagestern

Day Year) 32. Registrar's Signature 31. Date filed (Month)

Injury

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

		-	For State Registrar	State of	Marylan		ırtmen <i>tificat</i>			and M	ental Hyg	iene g. No.	07	19867
			1. Decedent's Name (First, Middle, Las	1)	· ·						2. Date of Deat Month	h Day	Yeer	3. Time of Death
	Physici: /Medic		Margaret F. Costo	n							May	28	2007	1530 ^M
	Examin		4a. Facility Name (If not institution, give		er)		4b. City,	Town, or	Location of	of Death	_	4c. Count	y of Death	
			Harrison Senior L					w Hi				Wo	rcest	
	Funeral		5. Social Security Number 6. Se	x 7. ☐ M 2[XF	Age (In yrs.	last birthday) Yrs.	If Under Months		If Under	Min.	8. Date of Birth (Month, Day,	Year)	9. Birth	
	Director		219–05–3908 Usuel Residence of Decedent		92	TIS.					Mar 12,	1915		VA
	and and	-	10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Mary	ō	MD Worces	ter	Sn	ow Hil]							1 TYes 2 □ No
	the 28a	Je C	10e. Street and Number				10f. Zip	Code			1	0g. Citizen of	What Cou	ntry?
	3a ol		501 Maple St., Ap	t. 404			2	1863				U	ISA	
	be filed within 72 hours after death with the Maryland ital Hygiane. Id other then "natural", or iteme 23s or 28s-f show event, Ire Medical Examinar must be notified at	Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U	.S. 13. \	Nas Dece	dent of Hi	spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)		ice - Ameri ack, White,	
٥	or Ite		1 ☐ Never Married 2 ☐ Married	1 Yes 2		1	ires, spe 1 □ Yes		Specify:	i, i deito i	ticati, otc.)	Spec		ack
3	ours Frei,	d by	3 ₩ Widowed 4 Divorced	Year or Date	es:			- ALIO	ороону.					
ر ک	72 h 'natu	Completed	15. Decedent's Ed (Specify only highest gra			16a. Deced	kind of wo	rk done a	during mos	t of workir		16b. Kind of I	Business/Ir	dustry
.7	hen hen	E E	Elementary/Secondary (0-12)	College (1-4	or 5+)	//re. I	ם NOT ע ספר	stodi	,			T1	niver	citu
N	filed v Hygia other t		17. Father's Name (First, Middle, Last)				Cua	stoui		er's Name	(First, Middle, I			SICY
ä	ntal hed of or	Be	Frank Dorsey								ounds		,	
Maryland 21215-0036	2 should be filed v and Mental Hygia ie marked other t raumatic event, IL	2	19a. Informant's Name/Relationship (vpe. Print)		19b. Mailir	ng Addres	s (Street a			l Route Number	, City or Town	n, State, Zij	o Code)
<u>s</u>	th ar th ar 27 to 1 trau	0 4	Margaret E. Welco			1018	Arli	inato	n Cou	ırt.	Warrent	on, MO	6338	3
စ်	es 1 and 2 should b of Heath and Ment fitem 27 ie marked r other traumatic e		20a. Method of Disposition		20b. F	Place of Dispo	sition (Na	me of	a)	D	ate	20c. Location	- City or T	own, State
Ê	Pages nent of I ant: #f Its ary or o		Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		ate	Zion			- 1	5/4/2	2007	Snow H	ill.	MD
Baltimore,	permit. Pages Department of Importent: If II any injury or once.		21. Signature of Funeral Service Licen	-		20	Name a	nd Addres	es of Facili	tv	eral Ho			
ñ	99 = 9		Jalana	talsi	70						sbury,		01	
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that cau	used the deat	th. Do not ent	er the mo	de of dyin	g, such as	cardiac o	r respiratory arr	est,	STORY	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_	CAST	CANC	CR	WIT	h A	1 STA	STAJES			Onset and Death
	/Medical		resulting in death)	u	r as a consec	quence of):								
	Examiner		Sequentially list conditions,	b							AH.102.1			
	si eq	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury	Due to (o	r as a consec	quence of):								
	and I-tran	Examiner	that initiated events resulting in death) Last	c	r as a consec	uence of):								
8760,	ate be executed hysician and the burial-transit													
687	the the	dical		d										
	leath certific attending p I for use as	Z.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			-					23d. D	ate of deliv	very
Вох	death a atte	Ca	in the past 12 months? 1 □ Yes 2 ☑ No	4☐ Pregna	th 2∐Feta ntattime of o		Ectopic p Other (s					N	Month	Day Year
o.	s that the de ned by the a deteched f	hys	9 □ Unknown	9□ Unknov	vn						-			
ď.	The law requires that the death certific ste has been signed by the attending p paga 2 should be deteched for use as	by Physician/Me	Part II. Other significant conditions of	ontributing to dea	th but not res	sulting in the u	nderlying	cause give	en in Part I	l.				the cause of death?
Division of Vital Records,	w require been signature should b	ed									1 U Y	es 2 TNo	3 ☐ Pro	bably 4 Unknown
ပ္ပ	e law re has be ja 2 she	Completed									24a. Was a autop	SV	. Were aut	opsy findings available ompletion of cause of
ř –	The ete h paga	ο.									perfor 1 ☐ Yes	med? 2 No	death? 1 ☐ Yes	212 No
ita	cian: ertific	Be	25. Was case referred to medical examiner?					104		e of Death	(Check only or	ne)		
<u> </u>	hysio this c	၉	1 ☐ Yes 2 ☐ No			ER/Outpatier			4 🗀 NI		me 5 Resid			ify)
Ē	ing P	Ö	27. Manner of Death 1 Natural 5 Pending		njury , Day Year)	28b. Time o Injury	м	28c. Injun World	yat k? Yes 2. [1	28d. Describe h	ow injury occ	urred	
Sic	Attending Physician: r death. ector: After this certifice by the funeral director, p	cat	2 Accident investigation 3 Suicide 6 Could not b		of Injune - At h	nome, farm, sti			165 2		28f Location (S	treet and Nur	mber or Ru	ral Route Number,
\leq	or All	Certification:	4 ☐ Homicide determined	building	g, etc. (Speci	fy)	eet, racio	iy, omce			City or Tow		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
_	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funarel Director: After this certificete ha completely filled in by the funeral director, paga		29a. Certifier 1 Certifying Ph	ysician: To the t	pest of my kn	owledge, deat	h occurre	d at the tin	ne, date a	nd place,	and due to the o	ause(s) and	manner as	stated.
	• Ho: • Fur etely	edical	(Check only 2 Medical Examone)	niner: On the bas and manne	sis of examina	ation and/or in	vestigatio	n, in my o	pinion, dea	ath occurr	ed at the time, o	date and place	e, and due	to the cause(s)
	withir To th comp	Me	29b. Signature and title of certifien	1					e number			29d. Date sign	ned (Month	, Dey, Year)
	NO.		Saly	M)			1)00	6217	2		6/6/2	2007	
	200		30. Name and address of person who	completed cause	of death (Ite				2			4.0	316	
	U		SHARAD R SATY		1604		KET	ST	row.	MOK	e Ciry	MD 2	1851	
6	Sta Regist		31. Date filed (Month, Day, Year)	007	gistrar's Sign	acure H	Land.	,						

DHMH 17 Rev 1/2001

Registrar

JUN_0 6 2007

			1 - For State Registrar	State of Mary		artment of F rtificate of			giene , Reg. No. 4 U 7	1935
	Obveiei	an	1. Decedent's Name (First, Middle,	Last)				Date of Dea Month	ath Day Year	3. Time of Death
	Physici /Medi		Chan Hwa C	hong					,2007	11:40p ^M
	Examir	ner	4a. Facility Name (If not institution,			4b. City, Town, o	r Location of De	ath	4c. County of Deatl	h
			Union Hosp: 5. Social Security Number 6		n yrs. last birthday		ton If Under 24 H	rs. 8. Date of Birt	Cecil	nplace (State or Foreign
14.	Funeral Director		221-60-0997	12€ M 2□F 70		Months Days	Hours M	n. (Month, Da	7, Year) Co.	South
			Usual Residence of Decedent	70	,			Junuary	2111331	Korea
	how at		10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Limits
	e Ma 3a-f s tiffied	cto	MD Cec:	i 1	E1ktor	1				1 ☐ Yes 🏖 No
	ith the	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	untry?
	s 23a	ral	1551 Augustin			2192		(Consite Van or No	U . S . A .	rican Indian
	item item	Funeral Director	 Marital Status Mever Married 2 Marrie 	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 21 No	r in U.S. 13.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Pu	erto Rican, etc.)	Black, White	
36	72 hours after death with the Maryland natural", or items 23a or 23a-f show disal Examiner must be notified at	by F	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: As	ian
215-0036	2 hou atura	ted	15. Decedent's	Education (1444)	16a. Dece	edent's Usual Occup	ation	varking	16b. Kind of Business/	Industry
215	~ · ·	ple	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)		e kind of work done DO NOT use retired		vorking		
2	filed within Hygiene. other than "	Completed	9		Owr	er/Oper			Chongs P.	roduce
Maryland	tal do do	Be	17. Father's Name (First, Middle, La	ast)				lame (First, Middle,	Maiden Surname)	
∑ Zla	should be ind Mental simarked o	은	Unknown	/T D-i-A	10h Mail	inn Address (Ctreet		nown	er, City or Town, State, Z	Zin Cada)
Mai	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic		19a. Informant's Name/Relationship						-	
	1 an Heal em 2		Won Chong/Sor 20a. Method of Disposition			osition (Name of ematory or other place		Date Date	y., Elkton 20c. Location - City or	
noi	ages ent of t: If It		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Hemovai irom State		ematory or other place 1. Manor		7,2007	Elkton,	MD
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra once,		21. Signature of 7 ine al Service Li			22. Name and Addre	ss of Facility			
B	Deparation of the permitted of the permi	ls /	1 Tel Tel			ndrew G				
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caused the	e death. Do not er	nter the mode of dyir	ain Si ng, such as card	liac or respiratory a	on, MD 2	interval Between
	Physician	6 1	Immediate Cause (Final disease or condition	Code	20 0	meet				Onset and Death
	/Medical		resulting in death)	a. Due to (or as a co	onsequence of):	JYESI				
	Examiner		Sequentially list conditions,	b. Cha	20	real	Insu	Morare	204	
	TD #≅	ner	cause. Enter Underlying Cause (Disease or injury	Con to (or on a m	unsuquence off:	(V-0		More	,	
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· Core	ory	okry	d	00000	>	
60,	be ex cian a	E	vocationing in detail, detail	Due to (or as a co	onsequence or).					
68760,	ficate be executed physician and is the burial-transit	edical	`	d						
_	death certifi attending I for use as	/Me	IF FEMALE:	23c. If yes, outcome pf	oregnancy				23d. Date of del	iverv
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	☐Ectopic pregnanc	у		Month	Day Year
P.O.	the d y the tched	Physician/M	1 □ Yes 2 □ No 9 □ Unknown	9□Unknown						
	The law requires that the death certif tte has been signed by the attending page 2 should be detached for use as	by Pł	Part II. Other significant condition	s contributing to death but n	ot resulting in the	underlying cause giv	ren in Part I.	23e. Did t	obacco use contribute to	the cause of death?
Records,	quire en sig uld b							_ 1 _ 1 _ 1	Yes 2□No 3Pr	obably 4 Unknown
000	aw requir s been si 2 should	olete						24a. Was	an 24b. Were au	topsy findings available completion of cause of
	The I	Completed						- autop perfo	ormed? death? 2. No 1 ☐ Yes	V
ita	lan: rtifice stor, p	BeC	25. Was case referred to medical examiner?			- 4	26. Place of [Death (Check only o		
or Vital	Physician: The law this certificate has braid irector, page 2 s	10E	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient	2ER/Outpatie		4 🗆 Nursin	g Home 5□Resi	dence 6 □Other (Spe	cify)
	ding P		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time Injury	Wor		28d. Describe	how injury occurred	
Sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not	A beautiful and the second sec	44 h awa 6 awa 6		Yes 2 ☐ No	005 1	Ot a stand Month as a D	and Double March and
Division	I or Attend after death. Director: /	Certification:	4 Homicide determin		- At nome, farm, s Specify)	теет, тастогу, оптов		City or Tol	Street and Number or Ru wn, State)	urai Houte Number,
	pital ours a eral filled		29a, Certifier 1 Certifying	Physician: To the best of r	nv knowledge, dea	ath occurred at the ti	me, date and pl	ace, and due to the	cause(s) and manner as	s stated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical		xaminer: On the basis of ex	kamination and/or i	investigation, in my	opinion, death o	ccurred at the time,	date and place, and due	e to the cause(s)
	lo th vithin Го th	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Mont	h, Day, Year)
			(Yolker	BULD		1700	2000	+26	6/5/20	07
			30. Name and address of person w	ho completed cause of deat	h (Item 23a) (Type	e, Print)	, 6-	1	511 1. 111	001001
	5		Orden Ce	resaygan	MD	223	wm	alu 7x	CIEDAING	0 21321
	St Regist	ate rar	31. Date filed (Month, Day, Year)	6 2007 Lu	signature &	Soule			29d. Date signed (Mont 6/5/20 Elk.km, M.	
	- negist	-	0011	- Lyur Parker	444					

			1 - For State Registrar	State of Maryla			of Health a of Death	and Me		jiene eg. No.	007	10355
	Physici /Medic		Decedent's Name (First, Middle, Las Lillian	К.		Cox			2. Date of Dea Month June	3, Day	200 7 °	3. Time of Death 6:45P M
	Examir		4a. Facility Name (If not institution, give Collingswood Nurs:	ing & Rehab (Rock	own, or Location o			M	County of Death	
	Funeral Director		203 07 3 103	7. Age (In yr	9 Yrs.	Months 1	Year If Under Days Hours	Min. I	8. Date of Birth DeC 22,	1'91'7	9. Birthi Mien	place (State or Foreign Try) Igan
	Maryland I-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince C		city, Town or Li reenbel							10d. Inside City Limits 1 → Yes 2 → No
	th with the 23a or 28a	a! Direc	10e. Street and Number 22 Ridge Road, #208	3		10f. Zip C	^{ode} 770		1	-	en of What Cou	-
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Itam 27 is marked other than "natural", or Itame 23a or 28a-f show or other traumatic event, the Madical Exambirat must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No ff Yes, Give Year or Dates:		Was Deceder If Yes, specify 1 Yes 2	nt of Hispanic Ori Cuban, Mexican XNo Specify:	gin? (Spec n, Puerto R	ofy Yes or No- lican, etc.)		4. Race - Amen Black, White, Specify: Wh	
Baltimore, Maryland 21215-0036	within 72 ho liene. r than "natur the Medical"	ompleted	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12		(Give	dent's Usual kind of work DO NOT use	done during mos retired)	t of working	g		d of Business/Ir	
land ?	should be filed and Mental Hygis marked other amatic event, III	To Be C	17. Father's Name (First, Middle, Last) Henry Kasten					er's Name ((First, Middle, i	Maiden S	Surname)	
Mary	and 2 should salth and Men n 27 le marke ier traumatic		19a. Informant's Name/Relationship (7 Deborah A. Isaacs		ž.		Street and Number rk Court				_	
more	permit. Peges 1 ar Department of Hea Important: If Itam any Injury or othe once.		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State Gr	Place of Dispersion of Place of Dispersion of Place of Dispersion of Place	matory or oth	of er place) Cemetery	Da 7 6/6/	-		enbelt,	own, State Maryland
Balt	permit. Pe Departmen Important: any Injury once.		21. Signature of Funeral Service Licen:	Marke	Ž 4	onald 400 Po	Wigger Borgv Wder Mil	∛ardt ll Roa	Funera ad Belt	l Ho svil	ome, PA 1e, Mar	yland20705
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the de- one cause on each line. aVentricula Due to (or as a cons Severe Aor	r Arryt	hmia	of dying, such as	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
8760,	death certificate be executed e ettending physician and for use as the burial-fransit	dicai Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons Coronary A Due to (or as a cons d.	equence of): rtery D							
.O. Box 6	that the death certific led by the ettending p deteched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ∑ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etef death 3	⊒Ectopic prec ⊒ Other (spec				2	3d. Date of deliv	ery Day Year
۵.	w requires that the been signed by th should be deteche	ğ	Part If. Other significant conditions or	ntributing to death but not r	esulting in the u	Inderlying cau	se given in Part f		23e. Did to			he cause of death?
Division of Vital Records,	The law ate has t page 2 s	Completed							24a. Was a autops perform		24b. Were autoprior to codeath?	opsy findings available impletion of cause of
<u> </u>	Physician: Th this certificate ral director, pag	Be c	25. Was case referred to medical examiner? 1 Yes X No	Hospital:			I		(Check only on			
on of	iding Phys th. After this funeral d	tion; To	27. Manner of Death 1A Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury		. Injury at Work? 1 ☐ Yes 2 ☐	28	8d. Describe ho		Other (Special occurred	(y)
Divisi	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, st	reet, factory,			8f. Location (Si City or Town	treet and n, State)	Number or Run	al Route Number,
	Hospital 24 hours a Funerel etely filled	edicai	29a. Certifier (Check only one) Certifying Physical Example 19 (Check only one)	rsician: To the best of my kiner: On the basis of exami	nowledge, deal ination and/or in	th occurred at evestigation, in	the time, date an my opinion, dea	d place, ar th occurred	nd due to the c d at the time, d	ause(s) a ate and	and manner as s place, and due t	stated. o the cause(s)
	Vithin 2 To the complete	Me	29b. Signature and title of conflier	M M)	1	icense number	243		9d. Date	signed (Mopth,	Day, Year)
_			30. Name and address of person who of Sayed Flsayyad, M	ompleted cause of death (ft) 9715 Medica	,		e Rockvi	ille,	Maryla	nd 2	20850	
7	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature K	packs						

P.O. Box 68760, Division or Vital Records.

To the Hosp within 24 hor To the Fune completely f State Registrar

ALLAN R SEGAL 32. Registrar's Signature 31. Date filed (Month, Day, Year)

MD

DHMH 17 Rev 1/2001

Medical

29a. Certifier

29b. Signature and title of certifier

30. Name and address of person who completed cause

of death (Item 23a) (Type, Print)

29c. License number

5117 HUGO CIRCLE SILVER SPRING MD

D52261

29d. Date signed (Month, Day, Year)

6/6/07

20906

	_	1 - For State Registrar		Ce	rtificate of D	eath		eg. No.		
Physic /Medi		Decedent's Name (First, Middle, L GUY WENDELL CA	,				2. Date of Dea Month June 5	Day	Year	3. Time of Death
Exami		4a. Facility Name (If not institution, g			4b. City, Town, or Lo	ocation of Death		4c. Count	y of Death	
		Collington Episc	-		Mitchel.					orge's
Funeral Director		218-30-4343	Sex 1 M 2 F 7. Ag	e (In yrs. last birthday 96 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 04-22-]	, Year)	9. Birthp Coun Virg	
natural', or leme 23a or 28a-1 show		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				1	0d. Inside City Lin
of a	ō	Morey I am 1 Day 1	0 1							1 ☐ Yes 2 🛚
28a-	Director	Maryland Prince	George's	Mitchell Mitchell	10f. Zip Code		1	Og. Citizen of	What Coun	itry?
34 04	0	10450 Lottsford	Road		20721			U.S.A		,
TI B Z	Funerai	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Spe	cify Yes or No-	14. Ra	ce - Americ	
Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23s or 28s-f show my julyry or other traumatic event, the Medical Exporter towal be rutified at once.		1 Never Married 2 Married 3 X Widowed 4 Divorced	Amed Forces? 1 A Yes 2 1 If Yes, Give Year or Dates:	No WWII		Mexican, Puerto I Specify:	Rican, etc.)		ick, White, fy: Whi	
Salf	Completed by	15. Decedent's I		16a. Dece	ident's Usual Occupation	on		16b. Kind of E	Business/Inc	dustry
T de la la la la la la la la la la la la la	piet	(Specify only highest g	rade completed)	(Give	kind of work done duri DO NOT use retired)	ring most of working	19	Depart		303H y
the d	Eo	Elementary/Secondary (0-12)	College (1-4or 5		nstration			of Agr		ure
othe	BeC	17. Father's Name (First, Middle, Las	it)		16	8. Mother's Name				<u>urc</u>
ked ked	To B	Oliver Wendell	Carmack			Minnie F	Pearl El	lis		
A THE	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Street and	d Number or Rura	l Route Number	. City or Town	, State, Zip	Code)
27 ls		Carolyn Ann Car	mack - Daug	hter 600	Wendron W	lay, Alex	andria.	VA 22	315	
Ite at		20a. Method of Disposition		20b. Place of Disp				20c. Location		wn, State
nt: ⊭ ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation /5 ☐ Other (Spec			an Cremato	ry 6/6/	2007	Alexar	ndria.	Virgin
orta inju		21. Sign Jure of Fuperal Service Lice			2. Name and Address of	-	2007			imore Av
Depa Impo any ir		Alut	11 per		Gasch's Fun	eral Hom	D D A			le, MD
physician and s the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Classes of injury that initiated events resulting in death) Last	c	a consequence of):						
attending physics as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome		☐Ectopic pregnancy				ate of delive	ry Day Year
ned by the a detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5[Other (specify)				,	Day 1 Sa.
5 3	by Ph	Part II. Other significant conditions	contributing to death br	ut not resulting in the u	inderlying cause given i	in Part I.				e cause of death
placed should	ted				-		1 ∐ Y∈	is 24LINo	3 [] Proba	ably 4 Unkn
S	Completed						24a. Was as autops	n 24b.	Were autop	osy findings avail
page	lo Uo						perform	ned?	death?	2 🗆 No
	Be (25. Was case referred to medical examiner?			26	6. Place of Death				
ctor	၉	1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatie	nt 3 DOA Other:	4 🖁 Nursing Hom	ne 5 ☐ Reside	nce 6 Ott	ner (Specify)
ns certificate ha I director, page		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	ry 28b. Time o	f 28c, Injury at Work?	2	8d. Describe ho	w înjury occur	red	
fter this certific neral director		2 Accident investigate				s 2 No				
After th funeral	atic		d 28e. Place of Inju	ury - At home, farm, st c. (Specify)	reet, factory, office	2	8f. Location (St. City or Town	reet and Numi , State)	ber or Rural	Route Number,
Director: After the in by the funeral	ertification	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined								
Funeral Director: After the fy filled in by the funeral	dical Certification:	4 ☐ Homicide determined	Physician: To the best of iminer: On the basis of and manner sta	examination and/or in	h occurred at the time, vestigation, in my opinion	date and place, a ion, death occurre	nd due to the ca d at the time, da	use(s) and mate and place,	anner as sta and due to	ated. the cause(s)
Funeral Director: After the	Medical Certification	4 Homicide determined 29a. Certifier 1 Certifying P (Check only 2 Medical Exe	Physician: To the best of iminer: On the basis of	examination and/or in	h occurred at the time, vestigation, in my opinion 29c. License no	ion, death occurre	d at the time, da	use(s) and mate and place, 9d. Date signe	and due to	the cause(s)
After th funeral	edical	4 Homicide determined 29a. Certifier (Check only one) 1 Certifying P 2 Medical Example (Check only one)	Physician: To the best of iminer: On the basis of	examination and/or in	vestigation, in my opini	umber	d at the time, da	ate and place, and place, and Date signe	and due to	the cause(s)
Funeral Director: After the lilled in by the funeral	edical	4 Homicide determined 29a. Certifier (Check only one) 29b. Signature and title of certifier	Physician: To the best of aminer: On the basis of arid manner sta	examination and/or in	29c. License nu D250	umber	d at the time, da	ate and place, and place, and Date signe	and due to	the cause(s)
Funeral Director: After the fy filled in by the funeral	edical	4 Homicide determined 29a. Certifier (Check only one) 1 Certifying P 2 Medical Example (Check only one)	Physician: To the best of aminer: On the basis of and manner start of the completed cause of decompleted cause of	examination and/or in the d.	29c. License nu D250	umber	d at the time, da	ate and place, 9d. Date signe	and due to d (Month, D	the cause(s) Day, Year)

			1 = For State Registrar AMEND#12per IN		-		artment of F rtificate of I		•	gien Reg. N	1.00 10	1 - 3 - 3
传	100		Registrar AVELLET IV Decedent's Name (First, Middle, La.		MDCD		imouto or i	-	2. Date of De	ath		3. Time of Death
	Physici		Billy Milliga		Clemer	nt			Month May 31		ay Year	8:15 p M
9	/Medio		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, or	r Location of Death			c. County of Dea	th
			Manor Care- Silv	er Spring			Silver	Spring			Mor	ntgomery
	Funeral		Social Security Number 6. S	Sex 7. Ag		st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Yea	r) Co	thplace (State or Foreign
	Director		115 12 1105	X M 2□ F	85	Yrs.			Aug. 6	, 1	.921 01	cláhoma
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	Maryl f sho	ō	Maryland Montgo	merv		Rocks	ri 11e					1 □ Yes 2 No
	the 28a-	Director	10e. Street and Number	Aug 1		T.OOR V	10f. Zip Code			10g. C	Citizen of What Co	ountry?
	3a or		13518 Vandalia D	rive			2	0853			USA	
	death ms 2	Funeral	11. Marital Status	12. Was Decedent I	ver in U.S	. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp	ecify Yes or No)-	14. Race - Ame	
9	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	/Fu	1 ☐ Never Married 2 Married	Armed Forces? 1 X Yes 2 ☐ If Yes, Give	1942-1949	- T	il Tes, specify oub		riicari, etc.		Black, Whit	nite
8	nours ural", I Exa	d by	3 Widowed 4 Divorced	Year or Dates:								
\overline{V}	"nat	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of work 1)	king	16b.	Kind of Business	Industry
12	withir ene. than he Ma	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5	+)		Placement			Non	-Profit	Organizatio
0	filled Hygi sther	ပ္	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	1		
lan	ld be ental ked o	To Be	Fred Rockwell Cl	ement				Miriam	Milliga	an		
Maryland 21215-0036	2 should be filed and Mental Hygi is marked other aumatic event, I	-	19a. Informant's Name/Relationship (_		ng Address (Street					
	and 2 alth a 27 is		Sarah K. Clement	:/Wife			.8 Vandal	-		llle	e, MD 208	353
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra		20a. Method of Disposition 13⊆18urial 2 ☐ Cremation 3 ☐	Domoval from State	20b. Pla	ice of Dispo metery, crei	osition (Name of matory or other place on Nation 2. Name and Addre	July	Date 10,		Location - City or	·
<u>Ĕ</u>	Pages ment of H ant: If ite ury or of		4 Donation 5 Other (Special		Ari	Lingto	n Nation	al Cemete	ery ²⁰⁰ /	Ar	lington,	, Virginia
at	eparti eparti porti ny Inj		21. Signature of Funeral Service Lice	nsee		1.5	dicis u.	COLLINS	runerai	Но	ome Inc.	
ш —			Acres &	O col	\/				·		er Sprin	ng, MD 20901
Ü.			23a. Part1. Enter the disease, or com shock, onheart failure. List only	plications that caused one cause on each lir	the death. ne.	Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	ırrest,		Approximate Interval Between Onset and Death
	Physician	1	Immediate Cause (Final disease or condition resulting in death)	a. Alzheir	er's	Demer	tia					
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):						
		<u>.</u>	Sequentially list conditions,	b. Due to (or as	a conseque	ence of):						
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease oi injury that initiated events resulting in death) Last	- 27 17 (71							-	
,	ificate be executed g physician and as the burial-transit	Xal	resulting in death) Last	C. Due to (or as	a conseque	ence of):		·				
68760,	e be sicial	edical		d .								
				7:								
Box	The law requires that the death certif tte has been signed by the attending bage 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			Ectopic pregnancy	V			23d. Date of de	
Ш	ed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at 9□Unknown			Other (specify)	<u></u>			Month	Day Year
P.0.	nat the d by ti etach	Phy	9 ☐ Unknown Part II. Other significant conditions		ut mat ranul	ting in the co	ndorhing pouco giu	ron in Part I	220 Did	tobacce	a uga captributa t	o the cause of death?
	ires the signer	by	Fait ii. Other significant conditions	ŭ		-		en in Faiti.				robably 4 □Unknown
0.0	w requires to been signer should be	eted	- Cerebral Contusi	ons							7	
Vital Records,	elaw hast	Completed							24a. Was		prior to	utopsy findings available completion of cause of
a	siclan: Th certificate rector, pag								1□ Yes	2 x N		2 □ No
₹	siclar certif recto	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:			oth Oth	26. Place of Dea				
Division or	Attending Physiclan: r death. ector: After this certifica by the funeral director, I	<u>۲</u>	27. Manner of Death	28a. Date of Inju	ry	28b. Time o	" 3LI DOX	4 LI Nursing H	ome 5 ☐ Hesi 28d. Describe		6 ☐Other (Spe	ecity)
on	iding I th. : After s funer	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da _j	y Year)	Injury		fk? Yes 2.∐No			,	
<u>IS</u>	or Attendatter death Director: in by the	lica	3 Suicide 6 Could not b 4 Homicide determined	Zoe. Flace of Hij	ury - At hor	ne, farm, sti	eet, factory, office		28f. Location (Street	and Number or R	ural Route Number,
á	al or after al Dir	Certification:	4 Hornicide	building, et	с. (эрвспу)				City or To	WII, SIB	1(e)	
	To the Hospital or Attending Physiclan: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page			hysician: To the best miner: On the basis o								
	the H iin 24 the F iplete	Medical	one)	and manner st		on ana/or II						
	with To 1	Σ	29b, Signature and title of certifier	11/	1	1	29c. Licens				Date signed (Mon	
	10+1		· Van	14 94	عد		D005	3235			June 4,	2007
	1071		30. Name and address of person who Darryl Hill, M				Print) e Avenue,	Laurel,	MD 2070	07		
	Sta Registi		31. Date filed (Month, Day, Year)	32 Registr	ar's Signati	ire Ap	NE STATE OF THE PARTY OF THE PA					
			2014 0 9 50	AR FEBRUAR		-						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1606 M CORNWALL 30 SUSAN 2007 MAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
June 28,1951 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days 1 □ M 2 🛛 F Maryland 55 Director 214-60-0940 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ns 23a or 28a-f shov must be notified at 1 ☑ Yes 2 ☐ No Director Germantown Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with United States Funeral 13243 Meander Cove Drive 20874 ral", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔯 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: Completed by 3 Widowed 4 Divorced White 'natural", d other than "natura event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Medical Librarian Medical alth and Mental Hygi 27 is marked other r traumatic event, ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Leland Earl Cornwall Frances Ruth Rasmussen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 i 13243 Meander Cove Dr. Germantown, Maryland 20874 Roberta J. Weaver / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ö 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 6/5/2007 Brentwood, Maryland 22. Name and Address of Facility Simple Tribute Cremation Center 21. Signature of Funeral Service Licer 1040 Rockville Pike, Rockville, Maryland 20852 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final HYPERKALEMIA UNKNOWN **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner ARTERY To the Hospital or Attending Physician: The law requires that the death certificate be executed CORONARY the burial-trans resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached t 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy s certificate ha performed 2 No 25. Was case referred to medical examiner?
1 res 2 No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 1 Natural 28b. Time of Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🗌 Yes 2 🗌 No death. neral Director: / rilled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral C completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 55068 MAY30,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

SHUBIR

31. Date filed (Month, Day,

Year)

05

2007

32 Registrar's Signature

SOPAT MD, 15825 SHADY GROVE ROAD # 60, ROCKVICE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** рм Margaret Ann Colby 31, 2007 8:30 May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🕱 F 096-32-9058 67 Nov. 2, 1939 Director New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examina. 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Silver Spring Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2709 Bellmawr Court 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 25 No Specify SpecifyWhite ģ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Educator Middle School Counseling 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) å Donnell Collins Anna Altschaeffl 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles P. Colby, Jr./Husband 2709 Bellmawr Court, Silver Spring, MD 20906 June Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2. Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2007 Alexandria, Virginia 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartfailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ischemic Bowel 1 Day /Medical Due to (or as a consequence of): **Examiner** Vascular Thrombosis 1**-**2 Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Gastro-Jejunal Resection 2 Days and burial-tra Due to (or as a consequence of) Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Recurrent Gall Bladder Cancer, Radiation Enteritis-Fibrosis, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Sepsis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. P.0. Division or Vital Records, funeral director, page 2 should After hours after death.

Medical Certification: To filled in by within 24 hours of

To the Funeral or

completely filled in

5 Pending investigation 6 Could not be determined 4 Homicide

nd title of certifie

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifie

29b. Signatur

(Check one)

28a. Date of Injury (Month, Day Year)

Injury

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

D12566

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

June 1, 2007

1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

30. Nameland address of person who completed cause of death (Item 23a) (Type, Print)

Berny Kreutz, M.D. 8600 Old Georgetown Road, Bethesda, MD 20814

and manner stated.

State Registrar

31. Date filed (Month, Day, Year) 2007 05



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death 30 Day 2007 **Physician** May 9:05a M Rudolph Cooper /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 6711 Terra Alta Prince George's Lanham Dr If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1 **X**M 2 ☐ F Director 75 Apr 26, 1932 Cades, SC 250-52-5667 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural" ~ " any injury or other traumatic every". 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County Lanham MD Prince George's 1 X Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? Street and Number U.S.A. 20706 6711 Terra Alta Dr Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ NOCt If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 A Married **Black** 1 ☐ Yes 2 TNo Specify: Specify: þ 1956 3 Widowed 4 Divorced ear or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lottie Anna Barr James George Cooper ပ 19a. Informant's Name/Relationship (Type. Print)

Margaret Cooper /Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6711 Terra Alta Dr, Lanham, MD 20706 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date June 5,2007 Brentwood, MD 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 22. Name and Address of Fācility Ft. Lincoln Funeral Home 21. Signature of Funeral Service Ligensee 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Coronary Thrombosis **Physician** /Medical Due to (or as a consequence of): Coronary Artery Disease Examiner 5 years Sequentially list conditions, if any, leading to infinished active cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examine or Attending Physician: The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 2 | No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes Hypertensive Cardiovascular Disease Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2□ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5X Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ANatural 1 ☐ Yes 2 ☐ No after death. 2 Accident the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

completely within 24 State

Medical

31. Date filed (Month, Day, Year)

Name and address of person who comp r. Lewis Marshall,

29b. Signature and title of certifier

(Check only one)



and manner stated.

DHMH 17 Rev 1/2001

Registrar

29c. License number MD25618

eted cause of death (Item 23a) (Type, Print) 1160 Varnum St, NE Ste 317, Washington DC 20017

29d. Date signed (Month, Day, Year)

5/31/07

		li	1 - For State Registrar	State of Mar		artment of H		, ,	iene _{eg. No:}	-	10372
	Physici /Medio		1. Decedent's Name (First, Middle, Last, YEANETT	4	HAPNI	CK		2. Date of Deal Month	Day	Year 2007	3. Time of Death
	Examir		4a. Facility Name (If not institution, give HEBREW HOME OF GRE	street and number)		4b. City, Town, o	r Location of De	ath	4c. County		
Ī	Funeral Director		5. Social Security Number 6. Sec		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hi Hours Mi				ace (State or Foreig try) MN
	Maryland I-f show	tor	Usual Residence of Decedent 10a. State 10b. County MD MONTO	OMERY	Oc. City, Town or Lo		OCKVILLE	3		10	0d. Inside City Limits
	with the ta or 28s	Director	10e. Street and Number 6121 MONTROSE ROAD			10f. Zip Code	20852		0g. Citizen of	What Coun	
020	be filed within 72 hours after death with the Maryland Hygiene. Independent the "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Modical Examinat must be notified at	by Funeral		12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:				(Specify Yes or No- erto Rican, etc.)		ce - Americ ck, White, (an Indian, etc.
Maryland ZIZIS-0036	filed within 72 ho Hygiene. Ither than "natur ant, the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retire BOOK KEE	during most of w d)	rorking	16b. Kind of B IMPOR MANUF	T/EXP	ORT
ylanu	should be filed void Mental Hygie of marked other tumatic event, in	To Be (17. Father's Name (First, Middle, Last) ALTER SEROTTO				BESSIE				
	nd 2 :		19a. Informant's Name/Relationship (Ty MARTIN GOROSH/NEPH	•	290 H	UDSON TE		PIERMONT,	NEW YO	RK 1	0968
Baitimore,	00		20a. Method of Disposition 1 □ Maurial 2 □ Cremation 3 ☑ F 1 □ Donation 5 □ Other (Specify)	lemoval from State	•	sition (Name of matory or other pla ARK CEMET	·		PARAMU		wn, State W JERSEY
Dai	permit. Page Department of Importent: ff any injury of once.		21. Signature of Funeral Service Incens]11	70 ROCKV	ILLE PIK	G MEMORIAL KE, ROCKVI	LLE, M	LS, II ARYLAI	NC. ND 20852
	oale be executed /Medical Examiner /Medical Examiner (the private transit)	Examiner	23a. Part1. Enter the disease, or complished, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Soundary Intocommediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	consequence of): 2 1 0 5 C L E			10 VIA SCLL		158175	Approximate Interval Between Onset and Death
.O. DOA 00/00,	death certificate e attending phy d for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 D No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy	/			te of deliver	ry Day [*] Year
r (SD)	w requires that the been signed by the should be detache	þ	Part II. Other significant conditions con ACUTE RENK		LURE	nderlying cause giv	en in Part I.		eacco use cont es 2 la No		e cause of death? ably 4 □Unknown
	The law ate has b page 2 sf	Completed						24a. Was an autops perform	y ned?	prior to com death?	sy findings available pletion of cause of 2 No
5	ding Physician: Thith. th.: After this certificate stuneral director, pag	ition: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 28a. Date of Injury (Month, Day Y	28b. Time of	28c. Injur	er: 4 Nursing	eath (Check only one Home 5 Peside 28d. Describe ho	nce 6 Oth)
DIVISION	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (· At home, farm, str Specify)	eet, factory, office		28f. Location (St. City or Town	reet and Numb , State)	er or Rurai	Route Number,
	the Hospi nin 24 hour the Funer npletely fill	edical	one) 2 Medical Examil	sician: To the best of r ner: On the basis of ex and manner state	camination and/or in	vestigation, in my c	pinion, death occ	curred at the time, da	ite and place,	and due to	the cause(s)
,	0 2 kg 2	×	29b. Signature and title of certifier Boungary	a file	every	29c. Licens	3543	6	MAY	19,2	2,007
_			30. Name and address of person who co BARBARA KAUA 31. Date filed (Month, Day, Year)	mpleted cause of deal	6121 MON	VIROX RI	OAD, Red	CKVILLE	= MD	200	152
	. Sta Registr	.6	JUN 0 5 200		Cignature	will					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#24a perPHYS, G868,6/20/07 WS
State of Maryland / Department of Health and Mental Hygiene

amend items 10e,f 11,15 pering 83/26e of 508thvt

Reg, No. 2011 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Caster 4:15 AM irginia 2007 06 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner UMMC Baltimore If Under 1 Year | If Under 24 Hrs 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1□M 2√F Months Hours Min. Country) 231 48 2540 Director 02/08/1938 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ns 23a or 28a-f shov must be notified at 1 ☐ Yes 2 ☐ No MD. Director BALTIMORE 10e. Street and Number 1703 Casadel Ave 10f. Zip Code 21230 10g. Citizen of What Country? 3522 JOANN DRIVE 21244-2923 Funeral U.S.A 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 🏝 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 🛣 Divorced "natural" er than "natur, the Medical R Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th. HOME MAKER DOMESTIC other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Is marked HAROLD CROXTON P LUCILLE CARTER CROXTON Health and Nitem 27 Is ma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN H. CASTER DRIVE BALTIMORE 3522 **JOANN** 21244-2923 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State EBENEZER BAPT-CHURCH 6(11)2007 4 □ Donation 5 □ Other (Specify) **SHARPS, VA. 22548** 22. Name and Address of Facility LEE funeralhome 21. Signature of Funeral Service Licensee MD.CC CC0240 12055 JAMES MADISON PARKWAY King George, Va. 22485 MAR W. Dee 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in allure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) hypertensive atheroscleration Vascular /Medical Due to (or as a consequence of): **Examiner** nknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9☐Unknown sate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2 No To the Hospital or Attending Physician: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Inpatient After this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0059790 06/2007 Karano and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drame. Rin S12A08, 22 BOX # Christopher Al. Marane 351 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUN 2 0 2007

			For State	State of Ma	rylan		artment of I rtificate of					3667		7
			Registrar 1. Decedent's Name (First, Middle, La	st)		Ce1	tillcate of	Dealii		2. Date of Dea	eg. No.	100 100 1	3. Time o	of Death
п	Physici		Ponziano Cramuto	la						May 24	Day 20	07	2:47	АМ
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, o	r Location	of Death		_	County of Deat	h	
		3	Holy Cross Hospi				Silver S					ntgomer		
1)	Funeral Director		5. Social Security Number 6. S 188–28–9189	Sex 7. Age IXM 2□F	(In yrs. i	last birthday) Yrs.	If Under 1 Year Months Days	Hours Hours	Min.	8. Date of Birth (Month, Day)	, Year)	Co	hplace (State untry)	_
	the season		Usual Residence of Decedent		70]]()1/31/1	93/	Penr	ısylvan	ııa
	irylan ihow I at	_	10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside (
	ne Ma 8a-f s	cto	Maryland Prince	Georges	G1e	enn Dal								s 2 No
	with the	<u>p</u>	10e. Street and Number				10f. Zip Code					en of What Co	untry?	
	eath	Funeral Director	12127 Northbrook		ver in U.	S. 13.1	20769 Was Decedent of F	Hispanic O	rigin? (Spec		USA 1	4. Race - Ame	rican Indian.	
(0	or Iten	FF	1 Never Married 2 X Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🛣	0		Was Decedent of I			lican, etc.)		Black, White		
21215-0036	ours a	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1□Yes 2ŽNo	Specify	/: 			Specify: Whi	te	
5-	n 72 h "natu edical	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation during mo.	st of working	g	16b. Kin	d of Business/	Industry	
121	withir ene. than he Me	dmc	Elementary/Secondary (0-12)	College (1-4or 5	+)		Manager	a)			Δ11 + Ο1	mobile		
	i filed I Hygi other ent, t	Be Co	17. Father's Name (First, Middle, Last)		baics	Hanager	18. Moth	ner's Name	(First, Middle, I				
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To B	Joseph Cramutola					Lucy	y Terl	Lingo				
lary	2 sho and 1 is ma auma		19a. Informant's Name/Relationship (Type. Print)		19b. Mailir	ng Address (Street	and Numb	ber or Rural	Route Number	r, City or	Town, State, 2	Zip Code)	
oʻ	l and lealth im 27 ther tr	1	April Larson/ Daug	ghter	Took D		Greenfie	eld Co						
Baltimore,	ages 1 nt of h : If ite	l i	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		20b. P	emetery, crei Metroi	sition (Name of matory or other pla DOLitan	ce)	Da			ation - City or		
Ħ	artme artme ortant injury		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice		L	Crema	atory 2. Name and Addre	:(05/26/			andria,		_
Ba	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau	7 5	Der F.Ker	i			6000 Anna						al non	ie
b	3.2		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death								Approxima Interval Be	ate etween
4	Physician	1	Immediate Cause (Final disease or condition	a Emphyser									Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequ									
		-	Sequentially list conditions,	b. Small Co			ancer Wit	h Ple	eural	Effusi	on			
	rted Insit	mine	il any, leading to immediate cause. Enter Underlying Cause (Disease or injury	240 10 (0) 43 0	Consequ	301100 017.								
Ć,	execuin and ial-tra	Examiner	that initiated events resulting in death) Last	C Due to (or as a	consequ	uence of):								
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical		_ d										
	death certifica attending ph		IF FEMALE:											
Вох	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 🗀 Fetal	Ideath 3□	Ectopic pregnanc Other (specify)	у			23	3d. Date of deli Month	ivery Day	Year
P.O.	res that the de	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	ume or de	eath 5L	Uther (specify) _							
	s that ned by deta	by Ph	Part II. Other significant conditions	contributing to death bu	t not resu	ulting in the u	nderlying cause giv	en in Part	l.	23e. Did tol	bacco us	e contribute to	the cause of	death?
Records,	w requires been sign should be									1 □ Y	es 2	No 3□Pr	obably 4 🛚	Unknown
9	e law requ has been je 2 shouli	Completed								24a. Was a		24b. Were au	topsy findings completion of	s available
E B	The cate h	Com								perform	med? 2 X No	death?	2 □ No	04400 0.
Vital	Physician: The this certificate har director, page	Be	25. Was case referred to medical examiner?	Hospital:			Oth			(Check only on				
o	Phys r this ral di	To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 X Inpatier 28a. Date of Injur		ER/Outpatier 28b. Time of	II JUDON	4 🗆 1		e 5 Reside			cify)	
on	Attending I r death. ector: After by the funer	tion	1XXNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	f 28c. Inju Wo M 1	rk?]Yes 2.[,,			
Division	l or Attendatter death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of inju	ry - At ho . <i>(Specif</i> y	me, farm, str	eet, factory, office		28	3f. Location (St City or Town	reet and	Number or Ru	ıral Route Nu	mber,
	ital or rs afte ral Dir lled in	Cert												
	Hosp 24 hou Fune rtely fi	Medical	29a. Certifier 1 X Certifying Pt (Check only one) 2 Medical Example (Check only one)	nysiclan: To the best on miner: On the basis of	examinat	wledge, deatl tion and/or in	n occurred at the ti vestigation, in my	me, date a opinion, de	and place, a eath occurre	nd due to the c d at the ti <mark>me</mark> , d	ause(s) a late and _l	and manner as place, and due	stated. to the cause	(s)
	To the Hospital of within 24 hours at To the Funeral Completely filled it	Mec	29b. Signature and title of certifier	and manner sta			29c. Licens	se number		2	9d. Date	signed (Month	h, Day, Year)	
	r s r ö		De /0	Jel Jayan	Fi"		D0052	258				/2007		
	h .		30. Name and address of person who	completed cause of de	ath (Item	23a) (Type,					0,02	, 200,		
	3 DM.		Patel Jayanti, M				n Road Si	[lver	Sprin	ng, MD	2091	0		
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 4 2(32. Registra		ture								
	-		6.0											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Martin Richard Costello May 31, 2007 5:30P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1908 Chester Drive Chester Oueen Anne's 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1 XM 2 □ F Yrs. 226-42-2930 69 June 2, Director 1937 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Queen Anne's Director Maryland Chester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1908 Chester Drive United States 21619 Funera 14 Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after N Yes 2 No 1954 — HYes, Give Year or Dates: 1957 1 Never Married An Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify. þ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Heavy Equipment Operator Construction d 2 should be filed with and Mental Hygien 7 is marked other the permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, if 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martin Van Buren Costello Annie Elizabeth Rice ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1908 Chester Dr., Chester, Maryland Lola Faye Costello / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore Crematory 16/5/07 Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licens 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Melanoma **Physician** year /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner Cause (Disease or injury that initiated events resulting in death) Last certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the esn 23c. If ves, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ate has been signed by the atterpage 2 should be detached for Month Day in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 2 No 3 Probably 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only of 2 No Hospital: Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA P 1 Tyes Residence 6 Other (Specify) 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending (Month, Day Year) Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital or To the Hospital within 24 hours a To the Funeral L 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D52830 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

JUN 0 4 2007



1 - State Amend #8, perFH, g869, 7/2/07 TI Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Louise Martin Crisp May 31, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 16303 Argent Court Bowie 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **62**Date of Birth Month, Day, Year 01/14/1923 5. Social Security Number **Funeral** 1□M 2 Days Months Hours 048-16-2220 84 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at Directo Maryland | Prince George Bowie 10e. Street and Number 10f. Zip Code 20716 16303 Argent Court by Funeral 12. Was Decedent Ever in U.S.

Armed Forces?

T Yes 2 No

If Yes, Give 107.9 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1948–52 3 ₩idowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be La Ferriere David Martin Anna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16303 Argent Court, Bowie, Md. 20716 Nancy Crisp Weeks/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State Metropolitan 06/03/2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home Knu 16000 Annapolis Road, Bowie, Md. 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pulmonary hronic Obstructive Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician hed for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐No 4☐Pregnant at time of death 5 Other (specify) been signed by the s 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò Completed 24a. Was an autopsy 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, f 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3☐ Suicide determined 4 ☐ Homicide 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 037934 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7500 Greenway Conter Dive Green belt MOZETTO MD Stephanie Trifoglia,

Year \mathbf{P}^{M} 2007 8:31 4c. County of Death Prince George's Birthplace (State or Foreign Country) Maine 10d. Inside City Limits 1 Tx Yes 2 □ No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Own Home 20c. Location - City or Town, State Alexandria, Virginia Approximate Interval Between Onset and Death 715 Years 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month. Dav. Year) 6/1/2007

3. Time of Death

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 4 2007

Registrar's Signature

Reg. No.

3. Time of Death

10:10 P M

10d. Inside City Limits 1 ☐ Yes 2 🙀 No

Approximate Interval Between Onset and Death MONTHS

NEW YORK

Black, White, etc.

WHITE

1. Decedent's Name (First, Middle, Last)

DHMH 17 Rev 1/2001

ORIGINAL

State Registrar

31. Date filed (Month, Day, Year)

JUN 0 4 2007

29d. Date signed (Month, Day, Year)

Month

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

JUNE 2, 2007

M.D., 9500 ANNAPOLIS ROAD, SUITE A-4, LANHAM, MARYLAND gistrar's Signature

20706

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Month 5/31/2007 **Physician** 12:10 am Howard Duke CLark /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Fairfield Nursing Center Crownsville If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 8. Date of Birth Month, Day Year 11/11/1922 9. Birthplece (State or Foreign 6. Sex 1 (X)M 2 □ F 7. Age (In vrs. last birthday) **Funeral** Days Hours Min Country) Maryland 216-12-3785 Yrs. 84 Director Usuat Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location r than "naturel", or items 23a or 28e-f show 10b. County 1 ☐ Yes 2√ No Director MD Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21054 USA 319 Gambrills RD death 12. Was Decedent Ever in U.S.
Armed Forces?
1 25 No 1939—
If Yes, Give
Year or Dates: 1945 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or iten any injury or other treumatic event, the Medical Evant 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: δ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0·12) 10 Shop Forman Civil Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sarah Clark Joseph Duke Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zola Mae Clark 319 Gambrills Rd. Gambrills, MD 21054 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 6/4/2007 Crownsville, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Citien see 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ou teroves culax /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Line, Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetet death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an page 2 s autopsy performe 1 Yes 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) hours after death. Inerel Director: After this ce y filled in by the funeral direc Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicat Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ceptines 07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sing Olin Burne MD21061

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN $0^{\!\!\!\!\!\!\!/}1$ 2007

ORIGINAL

208 Crain

strar's Signature

		•	1 - State of Maryland / Department	artment of Health and M ctificate of Death	ental Hygier	2001	19379
Т	٠	3-	Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
	Physicia /Medid		Samuel Harrison Cutler		June 11,	2007	1240 P ^M
	Examin	1	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	h
			1401 Broadford Road	Oakland If Under 1 Year If Under 24 Hrs.	0.00	Garrett	
	Funeral Director		5. Social Security Number $(3.8 \times 1.3 \times 1.3 \times 1.3 \times 1.3 \times 1.4 \times 1.3 \times 1$	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Jan. 7, 1	ar) Co	hplace (State or Foreign untry)
			Usual Residence of Decedent		Jan. 7, 1	.930 VII	ginia
	ylanc		10a. State 10b. County 10c. City, Town or Lo-	cation			10d. Inside City Limits
	e Ma	ctor	MD Garrett Oa	akland			1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	untry?
	ath w		1401 Broadford Road	21550		USA	
	ltems Items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Never Married 2 ■ Married 1 ▼ Never Married 2 ■ Married	Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
2	irs aft	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 🗓 No Specify:		Specify:	Black
3-003p	72 hours after death with the Maryland Instural; or thems 23e or 28e-f show dical Exactions to a notified at		15. Decedent's Education 16a. Deced	dent's Usual Occupation	16b	Kind of Business/	Industry
7	thin 7	Completed	(Specify only highest grade completed) (Give life. L	kind of work done during most of workir DO NOT use retired)	ng		
V	filed within Hygiene. other than "	Con	None Non	ne		None	
2	tal Hy d oth	Be	17. Father's Name (First, Middle, Last) Thomas ———— Cutler		(First, Middle, Maid	_	`
aryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If I tem 27 is marked other than "natural", or thems 23e or 28e-f show or other traumetic event, if a Marical Examinating reast the notified at	٥		Mame		(unkr	· · · · · · · · · · · · · · · · · · ·
Mar	12 sh h and 7 Is m traum			ng Address (Street and Number or Rura			
a)	1 and 1 Health em 27 ther tr			Broadford Road, Oa	-	ary Land Location - City or	21550 Town State
<u></u>	nt of nt of the trick of or o			natory`or other place)		,	
saitimore,	artme artme ortani injury		'4 □Donation 5 □Other (Specify) Oakland (21. Signaty = 4 Funeral Service	Cemetery 6/14 Name and Address of Facility		kland, Ma . Second	
ğ	permit. Pages 1 and Department of Heali Important: If Item 2 any injury or other ance.			Stewart Funeral Hor			21550
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter	er the mode of dying, such as cardiac o			Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final				Onset and Death
	/Medical		disease or condition resulting in death) a. Chronic obstruction of the consequence of th	tive pulmonary	disease		yrs
	Examiner		Sequentially list conditions.				
	p =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	ecute and trans	Examine	that initiated events c.				
3/00,	be executed ician and burial-transit	E	Due to (or as a consequence of):				
	physic the l	dlcal	d				
X Q	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of del	iverv
X Q	death e atten ed for u	Iclan/M	in the past 12 months?	Ectopic pregnancy Other (specify)		Month	Day Year
<u>.</u>	t the c by the achec	hys	9 Unknown				
ı,	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ğ	enire en sig	ed t	Hypertension		1 Tes	2 □ No 312 Pr	obably 4 Unknown
ecords,	law re as be 2 sho	ompleted			24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
	0 = 0	Com			performed	? death?	2 No
VIII R	ysician: This certificate	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
010	Physician: this certific ral director,	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien		ne 5 Residence		cify)
Z Z	ding P. h. After I funera	lon:	27. Manner of Death Y Natural 5 □ Pending 28a. Date of !njury (Month, Day Year) Injury	Work?	8d. Describe how in	njury occurred	
IVISION	ttend death stor: , the f	Icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stri	M 1 Yes 2 No	28f. Location (Street	and Number or Ri	iral Route Number
<u>≥</u>	al or Attending P s after death. Il Director: After i id in by the funera	ertification:	4 Homicide determined building, etc. (Specify)	eet, ractory, onice	City or Town, St.		rai nodie rainbei,
	a Hospital or Attenc 24 hours after death 5 Funerel Director: etely filled in by the	0	29a. Certifier Certifying Physician: To the best of my knowledge, death	n occurred at the time, date and place, a	and due to the cause	(s) and manner as	stated.
	e Ho 24 h	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invane) and manner stated.				
	To the Hospital or Attuvithin 24 hours after de To the Funerel Directo completely filled in by the	Me	29b. Signature and title of certiful	29c. License number		Date signed (Monti	
			> Sonall tunter	D30035	06-	-11-200	7
			30. Name and address of person who completed cause of death (Item 23a) (Type,	•	Contract of		
			Donald R. Richter, M.D. 1533 Me	emorial Drive O	akland,	MD 215	50
:"	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 3 2007	Coule			
•_	· vicgisti	UII					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CARL CONN 0 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Cumberland Allegany 425 Pennsylvania Avenue 8. Date of Birth (Month, Day, Jan 12, If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Hours Min 1√ M 2□ F МD Director 216-22-6994 80 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City. Town or Location or 28a-f show notified at 10a State 10b. County 10d. Inside City Limits MD Allegany Cumberland 1√ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be r 425 Pennsylvania Avenue 21502 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1★1 Yes 2 □ No If Yes, Give Year or Dates: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Never Married ★ Married 1 ☐ Yes 2 ☐XNo Baltimore, Maryland 21215-0036 Specify Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed Medical 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Sheetmetal Worker Local 100 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Myers Anna Mae (Grady) Myers ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21502 permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra Patsy Conn wife 425 Pennsylvania Cumberland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/15/2007 Scarpelli Funeral Home, P.A. Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Sterrice Ligense 108 Virginia Avenue: Cumberland, MD 21502 23al Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 6 weeks /Medical Due to (or as a consequence of): Bone Disease Examiner Metastalic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Division or Vital Records, P.O. Box 68760, 2 sician and burial-tran Due to (or as a consequence of). Physician/Medical attending physic 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 □ Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 □ Yes 2 No 3 Probably 4 Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 21100 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death After t 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours To the Funeral 🛂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) auch Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Year)

9

32. Registrar's Signature

			- State Amend Item 24	State of Mar a per ver	ryland/Departs.,g869.0	artment of H 7/25/07dh Africate of L	ealth a eath			167	193	8
	Discontinu		1. Decedent's Name (First, Middle, Last)					2. Date of Month June	Death Day	Year	3. Time o	of Death
	Physicia /Medic		Vera Lorraine	DuBree		,		Jun		2007	0845	A ^M
	Examin		4a. Facility Name (If not institution, give str	reet and number)		4b. City, Town, or		f Death		ounty of Death	1	
			3024 Blue House			Street		14 Hrs. a B		arford		
	Funeral		5. Social Security Number 6. Sex	4 0535	(In yrs. last birthday) 1 7	If Under 1 Year Months Days	Hours	Min. (Month,	Day, Year)	Col	nplace (State ontry)	or Foreign
	Director	1	170-24-1579 Usual Residence of Decedent		7			July	17 , 192	9 Mary	<i>y</i> land	
	and w		10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside C	City Limits
	f sh	ō	MD Harford	l	Street						1 🗌 Yes	s 2X No
	28e	Director	10e. Street and Number			10f. Zip Code			10g. Citize	on of What Co	untry?	
	3a o		3024 Blue House R	≀d.		21154				U.S.A.		
	be filed within 72 hours after death with the Maryland tal Hygiene. Ide Hygiene. Ide other than "natural; or items 23s or 28e-f show other than "natural; or items 23s or 28e-f show event. I'm Medical Examination matter notified at	Funerai		2. Was Decedent E	ver in U.S. 13.	Was Decedent of H	ispanic Orig	gin? (Specify Yes or , Puerto Rican, etc.)	No- 1-	I. Race - Ame Black, White		
٥	after or ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X No)	1 ☐ Yes 2€No	Specify:	, i dono i nodii, oto.,				
3	rai', c	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		10 100 2210				SpecifyWhi		
ဂ်	72 h 'natu	Completed	15. Decedent's Educa (Specify only highest grade		(Give	dent's Usual Occup kind of work done	during most	of working	16b. Kin	d of Business/	ndustry	
N	within ene. than "	idu	Elementary/Secondary (0-12)	College (1-4or 5+	lite.	DO NOT use retired	1)		Tr	Home		
2	filed withi Hygiene, other than ent, the M		12		HON	memaker	19 Mothe	r's Name (First, Mide				
ב	be fi	Be	17. Father's Name (First, Middle, Last)	.l				ma Leona				
Maryland	should be nd Mental marked o	၉	Hugh Charles Scar		10h Mail	n a Address (Street		or or Rural Route Nu		Town State 2	(in Code)	
<u>a</u>	12 sho n and rismu reum		19a. Informant's Name/Relationship (Type			Sunshine			et. MD	21154	p 00db)	
	s 1 and 2 should if Health and Men Item 27 is marke other treumatic		Richard A. DuBree	e (SOII)				Date		ation - City or	Town, State	
0	90==		1 Seurial 2 ☐ Cremation 3 ☐ Re	moval from State		osition (Name of matory or other place	- 1					a
	ertmen ertmen ortent: injury		* 4 □Donation 5 □ Other (Specify)			1em. Gdns.	-	5/12/07	_	Air, M	arytan	<u>م</u>
Baltimore,	permit. Page Department o Importent: if any injury or		21. Signature of Funeral Service ticense	rUNS)	1)	Aberdeer	ı, Mar		001-33	P.A. 99	Annevine	
	Pnysician /Medical		23a. Part 1. Enter the disease, or compile shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	+ AR	CINSON		ig, such as	cardiac or respirator	y arrest,		Approxima Interval Be Onset and	etween
	Examiner	-e-	Sequentially list conditions, b.	Due to (or as a	ELLIPI annequence of):	DEMIA	<u> </u>					
	uted Insit	Examine	in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Ha	PERTE	NSION						
V	s be executed sicien and burial-transit	Exal	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):	0						
<u> </u>	ysicie	icai	d	BIP	OLAR	STATE						
68760,	ficate p phys	edic										
O. Box	he death certificate be executed the attending physicien and thed for use as the burial-transit	Physician/Med	IF FEMALE: 23 b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	tc. If yes, outcome of 1 Live birth 2 4 Pregnant at t	2 ☐ Fetal death 3	□Ectopic pregnancy	/		_ 2	3d. Date of del Month	ivery Day	Year
٣.	es that the de igned by the be detached	by Ph	Part II. Other significant conditions cont	tributing to death bu	t not resulting in the	underlying cause giv	en in Part I	. 23e. D	id tobacco us	e contribute to	the cause of	death?
ds,	uires I sign	d D						1	☐Yes 21	No 3⊟Pr	obably 4]Unknown
Record	The law requires that the ste has been signed by the bage 2 should be detache	Completed						24a. V a p 1 🗆 Ye	utopsy erformed?	death?	utopsy finding completion of	s available cause of
	ilclen: Th certificate rector, pag	Ö	25. Was case referred to medical				26. Place	of Death (Check or				
>	Physicien: this certificatal director,	To B	eyaminer?	ospital:	nt 2 ER/Outpatie	ent 3 DOA Ott		ursing Home 5 F	-	Other (Spe	cify)	
	ding Phy h. After this funeral d	tlon: T	27. Manner of Death 1	28a. Date of Injur (Month, Day	v 28b. Time	of 28c. Injui		28d. Descri	be how injury			
Division	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, farm, s . (Specify)	treet, factory, office			on (Street and Town, State)	Number or R	ural Route Nu	imber,
	To the Hospitel within 24 hours a To the Funerel Completely filled	Medical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of er: On the basis of and manner sta	examination and/or i	ith occurred at the ti nvestigation, in my o	me, date ar opinion, dea	nd place, and due to ath occurred at the tire	ne, date and	place, and due	e to the cause	
	To the To the To the Comp	X	29b. Signature and title of certifier			29c. Licens				signed (Mon		
	_		1// Orlung	OVI		D4	5921		JUA	IE 8.	2007	1
1	t		30. Name and address of person who con SYFD F. MAHMCO	mpleted cause of de	eath (Item 23a) (Type	Print)	DAI D	DAD Svit	= 212	MAR B=	AIR	21015
	Sta	ate	31. Date filed (Month, Day, Year)	32. R	r's Signature		10	THY WILL	c our	000	71770	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Clevester Roy Dixon 6;00 P May 28, 2007 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince Georges Hospital Cheverly Prince Georges If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Davs | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 X M 2 ☐ F 225-50-7289 67 11/16/1939 Virginia Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Y Yes 2 No Capital Heights Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20743 6704 Arlene Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mekco Master Carpenter 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lewis Dixon Cleopethra Stone 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6704 Arlene Drive Capital Heights, MD 20743 Francis Dixon/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CountyLine Baptist06/02/2007 Vernon Hill VA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Dunn & Sons Fune Tall Homes . NE Washington P. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Ruptured Abdominal Aortic Aneurysm Due to (or as a consequence of): Left Iliac Aneurysm Due to (or as a consequence of Congestive Heart Failure Due to (or as a consequence of) Hemorrhagic Shock 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year

Physician /Medical Examiner

and

attending physician

Physician

/Medical

Director

Funeral

δ

Completed

Be

2

MD

Examiner

Funeral

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mential Hyghen. Important: If flem 27 is anarked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Exminer must be notified at

Examine

Physician/Medical Completed by Be

Certification: To

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant Obesity 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3□ Suicide

s after de... *** Director: And

use as the burial-trar detached

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

To the Hospital within 24 hours a To the Funeral I Medical State Registrar

filled in by

in the past 12 months? Tyes 2 No

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant et time of death

1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

Injury

5 Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown 24a. Was an

autopsy performed? 2 X No 26. Place of Death (Check only one)

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cert

28a. Date of Injury

(Month, Day Year)

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29d. Date signed (Month, Day, Year) May 31, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

20785

(II m 23a) (Type, Print)

3001 Hospital Dr. Cheverly, Naficy, 32. Registrar's Signature

JUN 0 6 2007

5 Pending investigation

6 Could not be

07-04514 James W. Delano

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			- For State	Cert	ificate of	Death	,	Reg.		1 4 1 300
	Physicia al Exami	an/	Decedent's Name (First, Middle,Last)	N DEI	ANO			2. Date of Death Month D June 12, 20	Day Year	3. Time of Death 1635 hrs
	A EXAMIN		JAMES WARRE 4a. Facility Name (if not institution, give street and no		ANU 4	o. City, Town, or Loca		Duile 12, 20	4c. County of	
			5011 Somerset Street			Riverdale Park		In Date of Birth	Prince Ge	
	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. las	Yrs.		Hours Min.	APRIL 4	1	9. Birthplace (State or Foreign Country) MARYLAND
**	any		Usual Residence of Decedent 10a, State 10b. County	10c. City, T	own or Location	on				10d. Inside City Limits
5	<u> </u>		MD. PRINCE GEORGES	3	RT'	VERDALE				1 Yes 2 No
)	Aaryland 28a-f show 1 at once.	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of Wha	t Country?
5	th the Maryland 23a or 28a-f sho notified at once.		6308 PATTERSON ST.			20737			U.S	
	after death with the Maryland al", or items 23a or 28a-f she iner must be notified at once	Funeral	1 Never Married 2 Married Armed F			Decedent of Hispan es, specify Cuban, Me			14. Race - White,	American Indian, Black, etc.
	fter de [", or i		3 Widowed 4 X Divorced If Yes, Give Yes	2 X No er	1	Yes 2 X No sp	pecify:		Specify:	WHITE
	hours a	bg p	15. Decedent's Education (Specify only highest gra			's Usual Occupation ost of working life. DC			16b. Kind of Busi	ness/Industry
36	d be filed within 72 hours fental Hygiene. narked other than "natur event, the Medical Exami	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		E IMPROVEN			SELF	EMPLOYED
00-	led with fygiene other t	<u>۾</u>	17. Father's Name (First, Middle, Last)					(First, Middle, Ma		
21215-0036	uld be filed withi Mental Hygiene. marked other th	Be	JOHN DELA	ANO						YSON
MD 2	houl nd N is n	_0	19a. Informant's Name/Relationship (Type, Print)	HITTE		Address (Street an LEWINSVILI				
≥	Pages I and 2 shounent of Health and I ant: If item 27 is I or other traumatic		KATHLEEN DELANO/EX 20a. Method of Disposition	20b. P	lace of Disposi	tion (Name of cemete				City or Town, State
nore	ages 1 ent of F nt: If	g il	1 Burial 2 X Cremation 3 Removal 4 Donation 5 Other Specify:		rematory or oth	er place) CREMATORY	6-1	5-2007	RTVERD	ALE, MD.
Baltimore,	permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum:	1	21. Signature of Funeral Service Licensee	0111		ame and Address of AMBERS FUN				
			23a. Part I. Enter the disease, or complications that	MOC)091i 58	O1 CLEVELA	AND AVE	. RIVERI	ALE, MD	. 20737
	nysician Medical		failure. List only one cause on each line.					respiratory arrot	a, orroom, or mour	Between Onset and Death
Ē	xaminer			a consequence of)		cular diseas	se			
		<u>.</u>	Sequentially list conditions, b.	a consequence of						
_		Examiner	cause. Enter Underlying Cause							
)	icate be executed physician and the burial - transit		events resulting in death) Last Due to (or as d.	a consequence of): 					
Ć.	cate be executed physician and the burial - transi	Medical	X UNPENDED #25a,2	7, perME, g8	368 , 6/25	/07 TT			<u>.</u>	
8760,	ificate ig phys		23b. Was decedent pregnant in the	, outcome of pregn birth		tal death 3	Ectopic pregna	ancy	23d. Date of o	lelivery Day Year
Box 68	eath certifi attending for use as	sician	4 No. o No. o D. Holmour	nant at time of dea		ner (Specify)				
	the dea by the a	Phys	Part II. Other significant conditions contributing	nown to death but not re	sulting in the u	nderlying cause give	n in Part I.	23e. Did tob	acco use contrib	oute to the cause of death?
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as 1	b S						1 Yes	2 🗸 No 3	Probably 4 Unknown
rds,	requir been s	Completed						24a. Was a autops		ere autopsy findings available for to completion of cause of
ဝ၁၅	The law ate has	E D						perforr 1 🗸 Yes 2		eath? ✔ Yes 2 No
<u> </u>	cian: The certificate ector, page	Be C	25. Was case referred to medical examiner?				Death (Check			
Ş	Physic or this or al dire	일	1 Yes 2 No	Inpatient 2	ER/Outpatient 28b. Time of I	J DON			Residence 6	
Ö	nding Pl th. : After e funera	ioi i	1 Natural 5 Pending (Mor	th, Day,Year)	ZGD. Time Or i	" .	2 No	250. 20001130 11	on injury cooding	•
risio	or Attencafter death Director:	licat	2 Accident Investigation	ce of Injury - At ho	me, farm, stree	et, factory, office build	ding, etc.			r or Rural Route Number, City
ä	pital o ours af eral D filled i	Certification:	4 Homicide determined (Specification of the determined of the dete	1)				or Town, St	ate)	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page		29a. Certifier (Check only one) 2 Medical Examiner: On the basic	est of my knowledg	je, death occur	red at the time, date	and place, and eath occurred a	d due to the cause at the time, date a	e(s) and manner and du	as stated. ue to the cause(s)
	To the within To the comple	Medical	one) 2 Medical Examiner: On the basi and manner 29b. Signature and title of certifier			29c. License n				d (Month, Day, Year)
		-	() Idly	M		O.C.M.	E.		June 13, 20	007
			30. Name indiad ross of person who complited a	use of death (Item						
			Susan Hogan MD. Assistant Med			n Street, Baltim	ore, MD 21	1201		
	S	tate	31. Date filed (Month, Day, Year) 2007 32/	Registrar's Signatu	re Anga	DE D				

		For State		_		rtment of H	Health and N Death		iene _{eg. No.} 2		1 1 1
Physic		1. Decedent's Name (First, Middle, Las Mildred Mari	t)					2. Date of Deat	-	Year 2007	3. Time of Death 8-009 M
/Med Exami		4a. Facility Name (If not institution, give			Homo		or Location of Death		4c. Coun	ty of Death	L.,,,,,,,,,,
Funera Director		Renaissance Gardens - 5. Social Security Number 6. Social Security Num		7. Age (In yrs. la			if Under 24 Hrs. Hours Min.		Year)	9. Birthp	lace (State or Foreign
Maryland f show ed at	or	Usual Residence of Decedent 10a. State 10b. County Maryland Montgom	ery	10c. City	, Town or Loc	cation Silver Sp	oring			1	0d. Inside City Limits 1 □Yes 2 🗷 No
vith the I	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen o		
ING 21215-0036 be filed within 72 hours after death with the Maryland ital Hygiene. dother than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	3160 Gracefield 11. Marital Status 1 Never Married 2 Married 3 (X) Widowed 4 Divorced		dent Ever in U.S rces? 2 X No e	j.	Vas Decedent of I	20904 Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or No- o Rican, etc.)		U.S.A ace - Americ lack, White, cify: C	an Indian,
21215-0036 ad within 72 hours af giene. er than "natural", or , the Medical Exami	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1	-4or 5+)	(Give life. L	lent's Usual Occu kind of work done OO NOT use retire	during most of worked)		16b. Kind of	Business/Ind	•
- 0 = 0 S	Be	17. Father's Name (First, Middle, Last) Lawrence T					18. Mother's Nam	ne (First, Middle, i		ame)	
larytal 2 should b and Ment Is marked aumatic e	2	19a, Informant's Name/Relationship (· · · · · · · · · · · · · · · · · · ·	19b. Mailin	g Address (Stree	t and Number or Ru			ın, State, Zip	Code)
Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 Is marked oth any injury or other traumatic event		Don Dickinson - Son 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the control of the c		State C6	ace of Dispo emetery, cren	sition (Name of natory or other pla	nd, Northfie ace) metery June	Date	20c. Location	n - City or To	
Departmit. F Departmit Importariany injur		21. Signature of Eupergl Service Licer 23a. Parti. Enter the disease, or com	isee*		22 Hi 11	Name and Addr nes-Rinalo 800 New Ha	ess of Facility li Funeral H ampshire Ave	lome, Inc.	er Sprin		land 20904
icate be executed W/Medicate be executed physician and physician and street burial-fransit	dical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reauning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	or as a consequence or as	ience of): ience of): second	to -	ement Horive pression				Approximate Interval Between Onset and Death
Geath certife attending of for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐Live b	come pf pregna pirth 2 ☐ Fetal lant at time of de pwn	death 3	Ectopic pregnan Other (specify)	су			Date of delive Month	ery Day Year
hat be be be be be be be be be be be be be	ed by Ph	Part II. Other significant conditions of	contributing to de	eath but not resu	Ilting in the u	nderlying cause g	iven in Part I.	23e. Did to			he cause of death?
- 00	Completed							24a. Was a autop perfor 1□ Yes	sy	b. Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of
Division or Vital To the Hospital or Attending Physiclan: T within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pa	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 LAO 27. Manner of Death ADNatural 5 Pending 2 Accident investigation	28a. Date (Mon		ER/Outpatier 28b. Time o Injury	f 28c. Inj	ther: 4 Harsing H	ath (Check only or Home 5 Resid 28d. Describe h	ence 6 □0		fy)
DIVIS al or Atte s after dea al Director ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place	of injury - At ho ing, etc. (Specify	me, farm, str	eet, factory, office	9	28f. Location (S City or Tow		mber or Run	al Route Number,
the Hospital hin 24 hours a the Funeral	Medical	29a. Certifier (Check only one) 1 Certifying Ph	miner: On the b	best of my kno asis of examina ner stated.	wledge, deat tion and/or in	h occurred at the vestigation, in my	time, date and place opinion, death occi	e, and due to the ourred at the time,	cause(s) and date and plac	manner as s ce, and due	stated. to the cause(s)
To the within to comp	Me	29b. Signature and title of certifier	Puth	una	ng M	1	59524		June		Day, Year) 2007
, P		30. Name and address of person who Loveen Puthumana,	completed caus	se of death (Item	23a) (Type,	Print)	Spring. Man				
S Regis	tate	31. Date filed (Month, Day, Year)		egistrar's Signa		acts 1	·r	-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#25 perphys 7/26/07 WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2007 ear MAY 31, 5:35 A M MAXIE DANIELS 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) MONTGOMERY #2 Gaithersburg 438 N. Summit Avenue, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 28, 1953 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex N. Carolina 1**☑** M 2□ F 54 241-90-2115 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 No Gaithersburg Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20877 U.S.A. Summit Avenue, #2 438 N. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Willie Mae Dember Maxie Daniels, Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20877 19a. Informant's Name/Relationship (Type. Print) 438 N. Summit Ave, #2, Gaithersburg, MD Elizabeth Williams (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Ash Memorial Cem. 6/9/07 Sandy Spring, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Snowden Funeral Home P.A.
246 N. Washington St, Roc 21. Signature of Funeral Service Licentee A. 20850 Rockville, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fature. List only one cause on each line. Approximate Interval Between Onset and Death Sudden Immediate Cause (Final disease or condition resulting in death) Cardiac Arrythmia

Examiner The law requires that the death certificate be executed use as the burial-transi and Division or Vital Records, P.O. Box 68760, attending physician for use as the buria signed by the a been si certificate ha or Attending Physician: funeral To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Physician

/Medical

Physician

/Medical

Examiner

MD

Director

Funeral

þ

Completed

Be

ဂ္ဂ

Funeral

Director

72 hours after death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyghene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Mon

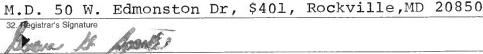
	Ahteriosclerot	ic Cardiovasc	ular Dis	ease	Yrs		
Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b						
that initiated events resulting in death) Last	C						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		otopic pregnancy ther (specify)		23d. Date of de Month	elivery Day Year		
	contributing to death but not resulting in the unde	erlying cause given in Part I.			to the cause of death? Probably 4 ☐Unknown		
			24a. Was an autopsy performer 1∐ Yes 21	? death?	autopsy findings available completion of cause of s 2 ☐ No		
25. Was case referred to medical examiner?		26. Place of Dea	ath (Check only one)				
examiner? 1 X Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing H	lome 5XX Residence	e 6 Other (Spe	ecify)		
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	njury occurred					
27. Manner of Dean 1 X Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, stree building, etc. (Specify)	t, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a Certifier 1 Certifying P	hysician: To the best of my knowledge, death o iminer: On the basis of examination and/or inve and manner stated.	ccurred at the time, date and place stigation, in my opinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner a and place, and du	as stated. ue to the cause(s)		
29b. Signature and title of certifier		29c. License number	29d.	Date signed (Mor	nth, Day, Year)		

State Registrar

31. Date filed (Month, Day, Year) JUN 05

Pankaj Talwar,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D-36552

June 1, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 07^{Year} Day Month 27 James Alfred Davit **Physician** 12:30PM /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Prince Georges 12411 Shore Drive Fort Washington 9. Birthplece (State or Foreign Country) Missouri If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, **Funeral** Days Hours Min. 10 M 2□ F 2/25/30 77 Yrs. 487-40-9725 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State or 28a-f ehow Examiner must be notified at 1 ☐ Yes 2 X No Fort Washington MD Prince Georges Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number USA 20744 12411 Shore Drive or Items 23a Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours atter c Depertment of Health and Mental Hygiene. Important: If Item 27 Ie marked other than "natural", or Item any Injury or other traumatic event, the Medical Examine 1 ☐ Yes 2 **X**No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specity: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Admin during most of working Certified Public College (1-4or 5+) 5+ Small Business Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (Eirst, Middle, Last)
Alfred Davit Be Verne Henninger ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12411 Shore Drive Fort Washington, MD Dawn Davit/ wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Riverdale, MD 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crematory 21. fignature of Funeral Service Ciconse 22. Name and Address of Facility 420 H St. NE BK Henry Funeral Chapel Wash, DC 20002 White 23a. Part1. Ener the disease, or complications third bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause color line. Approximate Interval Between Onset and Death Immediate Cause (Final a mouthe Luna Concer Physician resulting in death) /Medical Due to (or as consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Completed by Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month þ in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No be detached the P.0 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an page 2 autopsy performed' 1 ☐ Yes 2 ☐ No 2 No 1 Yes Division of Vital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 🕱 No 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Diractor; in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 07

(p (7)

State Registrar Monacs MD 8926 Wordyard Rd 32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

(linton M) 20735

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 7:22P.M. JUNE 2007 Dorothy May Dawson 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Reeders Memorial Home Washington County Boonsboro If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 12 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Min. Months 1 ☐ M 2**X** F 87 Yrs. 577-18-7011 1919 Washington DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Boonsboro Maryland Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21713 USA 141 South Main Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (Z)No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Bookkeeper Elementary/Secondary (0-12) College (1-4or 5+) Storage Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elmer Bageant Ethel May Drake 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Evie Rohrer niece 1539 Violet Drive Hagerstown Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Rose Hill Cemetery June 7 2007 Hagerstown Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee Kaitlin 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the dise set or conflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Conservy Due to (or as a consequence of) Antemo Schendiz Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably 4 | Clumknown Anem 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 1 No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Anursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the Innertal director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Directo

Funeral

þ

Completed

Be (

ဂ

Funeral

Director

show

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

ith and Mental Hygiene.
27 Is marked other than "r
r traumatic event, the Med

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once.

Physician

/Medical

Examiner

Physician/Medical 23b. Was decedent pregnant þ Completed Be 25. Was case referred to medical examiner? Certification: To 27. Manner of Death 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

29b. Signature and title of certifier

1 Yes 2 No

D (8019

28f. Location (Street and Number or Rural Route Number, City or Town, State)

JUNE 5, 200)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

CM DUST

VASANT DATTA, 340 MILL STREET, HAGERSTOWN, MARYLAND 21740 301-739-7100 JUN () & 31. Date filed (Month) 32. Registrar's Signature

State Registrar

BH-1

Physician /Medical Examiner **Funeral** Director show. the Medical Examiner must be notified at Director 28a-f items 23a or Funeral Maryland 21215-0036 ٥, δ "natural" Completed than "

Baltimore,

DIXON

certificate be executed Box 68760, attending physician the nse 20 P.O. detached þ Records, has certificate Division or Vital

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month MAY 2007 Dixon Trane 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MEMORIAL HOSPITAL E ASTON 1 ALBOT If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 ☐ M 2 🔀 F 212-26-5234 Usual Residence of Decedent 28 1930 S. Carolina 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Marvland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1050 Cedar Avenue 21061 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2K No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dixon Electric, INC permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If item 27 is marked other ths any Injury or other traumatic event, the once. 11th Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George N. Williams Rosie B. Gosby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Thomas H. Dixon Jr. (Husband) 1050 Cedar Ave. Glen Burnie, Md. 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 ☐ Cremation 3 □ Removal from State Metro Crematory 6/2/07 4 Donation 5 Dother (Specify) Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Reese & Sons Mortuary, West St. Annapolis, Md Lavy B. Keese MOOY83 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) on considered **Physician** ornmunity /Medical Due to (or as a consequence of : Examiner Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner nistary Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an nishin autopsy performed? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dir 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 21/1 31. Date filed (Month, Day, Year) Registrar's Signature State JUN 0 4 2007 Registrar

07-04507	
----------	--

Ri

chard Mokniley	1	- For State Certificate of Death		eg. No.	y97 1908
Physicia	_	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Dea	th	3. Time of Death
ledical Examir	ner	Richard McKinley Dolly	Month June 12, 2		1051 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Allegany	Death
	۹,	102 East 1st Street Cumberland Street 5. Social Security Number	8 Date of Bir		9. Birthplace (State or
Funeral Director		Months Days Hours Min			Foreign
Birector	-	220-34-1860 1 _X M 2 F 69 Yrs.	6-3-19	938	MD_
any	1	Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	_	MD Allegany Cumberland			1 X Yes 2 No
Aaryland 28a-f show	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of Wha	it Country?
ith the Maryland 23a or 28a-f sho notified at once.		102 East First Street 21502		USA	
ms 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S		- 14. Race - White,	American Indian, Black, etc.
or ite	5	1 Yes 2 X No	raban, oto.,		
s after rral", niner	<u>a</u>	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of Victoria)	work done	Specify:	white
2 hour "natu Exar	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		Tob. Tana or Bas	mood modely
336 thin 7. re. than edical	휌	12 laborer		orchar	-d
21215-0036 und be filed within 7 Mental Hygiene. marked other than	ड		e (First, Middle,	Maiden Surname)	
121 lbe fil ental l arked vent,	a	Matthew M. Dolly Edna A	Ash		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	٩	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or			
, MD and 2 sho ealth and em 27 is	ŀ	Mary Crutchley/sister 169 E. Wilson Road. (20a, Method of Disposition 20b. Place of Disposition (Name of cemetery,	Oldtown Date	MD 2155 20c. Location -	City or Town, State
ore ges 1 t of H : If it		1 X Burial 2 Cremation 3 Removal from State crematory or other place)			
Baltimore, permit. Pages I ar Department of Hee Important: If ite	ŀ				stone, MD
Ba Perm Depa Injur		108 Virginia Ave.	Cumber	funeral	Home, P.A.
Physician		236 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of fallure. List only one cause on each line.	or respiratory ar	rest, shock, or hea	rt Approximate Interval Between Onset and
/Wedical Examiner	1	Immediate Cause (Final disease a. Atherosclerotic cardiovascular disease			Death
zammer		or condition resulting in death) Due to (or as a consequence of):			
	<u>,</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	Cusease or injury that initiated			V.
19 & C/1.	Exal	events resulting in death) Last Due to (or as a consequence of):			
be execute sician and ourial - tran	dical	UNPENDED AMENDED 27 POMME 2969 6/21/07 TTP			
	ω .	IF FEMALE: AMENDED #23a,27,perME, g868, 6/21/07 TT 23c. If yes, outcome of pregnancy		23d. Date of	delivery
Box 6876(e death certificate the attending physed for use as the b	N/U	23b. Was decedent pregnant in the past 12 months? 25b. If yes, dutchine of pregnancy 25c. If yes, dutchine of pregnancy 25c. If yes, dutchine of pregnancy 25c. If yes, dutchine of pregnancy 25c. If yes, dutchine of pregnancy 25c. If yes, dutchine of pregnancy 25c. If yes, dutchine of pregnancy	ancy	Month	Day Year
ox 6	뱛	Pregnant at time of death 5 Other (Specify)		Ĩ	
. BC	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use contril	bute to the cause of death?
ires that the signed by t	þ	Tarri. Other significant conditions contributing to dead partial residing in the disconning access given in tarri.		es 2 No 3	Probably 4 V Unknown
rds, require been sig	Completed		24a. Was		Vere autopsy findings available
cords law requi has been	힐			ormed? d	rior to completion of cause of eath?
tal Rectian: The certificate ector, page		25. Was case referred to medical 26. Place of Death (Check	1 Yes	2 No 1	Yes 2 No
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should the	Be	examiner? Hospital: 1 Inaction 2 FP/Outration 3 DOA Other; Nursi	ina Home 5	Residence 6	Other:
of Vil ing Physic After this uneral dir	P L	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe	how injury occurre	ed
ion of tending Pheath.	틽	1 X Natural 5 Pending (Month, Day, Year) 1 Yes 2 No			
/iSi	ţį	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.			er or Rural Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director:	Certification	4 Homicide determined (Specify)	or Town,	State)	
Hosp 24 hc Fun etely f		29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an			
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner-stated.	at the time, date		
	Σ	29b. Signature and fittle of certifier 29c. License number O.C.M.E.		June 13, 20	ed (Month, Day, Year)
				Julie 13, 20	
		30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	1201		
91	ate				
Regist		JUN 1 9 2007 Sterger H. Aparles			
DHMH 17 Rev 1/2	001	ORIGINAL			

			Please T	ype or Print in B				-		egible.		
			For State Registrar	State of Maryland	•	irtment of F tificate of		лептат Ну			1.6	
	-		Registrar Decedent's Name (First, Middle, Last)			incate or	Douin	2. Date of De	Reg. No.	Car Tur d	3. Time of	Death
	Physici		CATHERINE DORI	S DEMENT				JUNE	9, Day	007 Year	4:05	РМ
	/Medio Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Death	1		County of Deat		
			SO.MARYLAND H			CLIN				G		
	Funeral		5. Social Security Number 6. Sex	M OF E		if Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da	ay, Year)	Co	nplace (State o untry)	r Foreign
	Director		215-64-5545 Usual Residence of Decedent	7 · 7	/ 113.			8-2-	1929	MD.		
	yland iow at		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside Ci	ty Limits
	a f st	ģ	MD. CHARLES	S		WALDORF	1				1 ☐ Yes	2 X No
	72 hours after death with the Maryland 'natural', or items 23a or 23a-f show dical Examiner must be notified at	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Co	untry?	
	ath w	ra		MAN-BEANTOW		206			U.S.		dana ta dina	
	item item	in in	11. Marital Status 1 ☐ Never Married 2 ☐ Married	I2. Was Decedent Ever in U.\$ Armed Forces? 1 ☐ Yes 2 No	S. 13. V	vas Decedent of F f Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.))- '	 Race - Ame Black, White 		
36	urs af al", or xami	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	∏Yes 2∭XNo	Specify:			Specify: W	HITE	
21215-0036	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Deced	lent's Usual Occup	pation during most of work	rina	16b. Kin	d of Business/	industry	
21	within iene. than "I	aple.	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OONOT use retire	d)	an g	OW	N HOME	1	
	al Hygie other ti vent, th	Š	17. Father's Name (First, Middle, Last)		п	JEEMAKE.	18. Mother's Nam	e (First Middle	_			
and	d be f ental l ced or	To Be	CHARLES WINI	SOR			GRACIE			ourname,		
Maryland	2 should be and Mental is marked an aumatic ev	ř	19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Street	and Number or Ru			Town, State, 2	lip Code)	
	9 £ 5 #		LINDA ENNIS-DA	AUGHTER	9006	BUTTON	S DRIVE	CLINT	M, NC	D.2073	5	
ore	of He fitem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R		lace of Dispo	sition (Name of natory or other pla		Date	20c. Loc	cation - City or	Town, State	
Ë	Pages Iment of tant: If its jury or o		4 ☐ Donation 5 ☐ Other (Specify)	TRINIT		A.GARDE				DORF,M	ID.	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service License	M00479	(22 H	. Name and Addre	FUNERAI	SERV	ICE,	P.A.		
	442 00		23a Part1 Enter the disease or compli	cations that caused the death			A,MD. 20		rrest		Approximate	e
_	Dhysisian		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final								Approximate Interval Bet Onset and I	Death
	Physician / /Medical		disease or condition resulting in death)	Due to (or as a consequence of the consequence of t	ience of):	. Mesky	1 150	1000	ton.		Admi	6107
	Examiner		Sequentially list conditions	Rheur	nant	ir He	art D	riseau	محر		Expire	
10	p ii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience off;						on 6/9	7107
MA	e executed sian and urial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ		rentti	cience	1				605
,09	be ex ician burial			Due to (or as a consequ	ience on.			•			hours	
Box 6876	Attending Physician: The law requires that the death certificate be refersh. ctorath. ector: After this certificate has been signed by the attending physicia by the funeral director, page 2 should be detached for use as the but	Completed by Physician/Medica	d									
×	n certi	n/M	IF FEMALE: 23b. Was decedent pregnant	3c. if yes, outcome pf pregna		In			2	3d. Date of del	very	
Ö.	death	sicia	in the past 12 months? 1 ☐ Yes 2 🖼 No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown]Ectopic pregnand]Other (specify) _	у			Month	Day	Year
P.O.	at the	Phys	9 Unknown					00 Did				
	res th	by	Part II. Other significant conditions con	britand on death but not resu	-	iderlying cause gi	ven in Part I.			se contribute to	the cause of d obably 4 □ l	
oro:	requirements	eted	1,01, 1,		*							
Rec	has by	mple						24a. Was		24b. Were au prior to death?	topsy findings completion of c	available ause of
a	in: Th		25. Was case referred to medical				00 Di	1□ Yes	2 No	1 ☐ Yes	2 ☐ No	
Š	ysicia s cert directe	To Be	examiner?	lospital: 1 ⊠Inpatient 2 🔲 I	ER/Outpatien	t 3 DOA Oti	26. Place of Deather: 4 ☐ Nursing Ho			□Other (Spe	oifu)	
0	g Phy ter thi	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury			28d. Describe			Say/	
Siol	endir sath. or: Af the fur	atio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1 □	Yes 2 □ No		_			
Division or Vital Records,	or Att fter de Direct in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, stre ')	eet, factory, office		28f. Location (City or To	Street and wn, State)	f Number or Ru	ıral Route Num	ber,
	pital ours at eral C		29a. Certifler 1 Certifying Phys	sician: To the best of my know	wledge death	occurred at the t	ime, date and place	and due to the		and manner of	atatad	
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Medical	(Check only one)	ner: On the basis of examinat and manner stated.	tion and/or in	vestigation, in my	opinion, death occu	rred at the time	, date and	place, and due	to the cause(s	3)
	To th within To th	Me	29b. Signature and title of certifier	. 1.1	. N	29c. Licens			29d. Date	e signed (Monta		-
			Jalish &	man F	,	D3	5295			6/11	107	
	G		30. Name and address of person who co		23a) (Type,	Print)	S . va 2	ر د د د د د د د د د د د د د د د د د د د	2 1	i AI A.	82 M	Δ.
	V		>4 1124 1014	401 1-612 1	0 7L.1	-00 11-0-	- 1-1 . 3		-0			

Registrar

State

32 Registrar's Signature El Alexan

20603

			1 - For State Registrar	State of Ma	arylan				lealth a D <i>eath</i>	ind M		giene. Reg. No.	1. 5 1	15021
			1. Decedent's Name (First, Middle, Last,				-				2. Date of Dea Month	ath Day	Year	3. Time of Death
Н	Physici /Medic		Leah	F	ele	65					June	3	200	Z 16:03(PM)
4	Examin		4a. Facility Name (If not institution, give				4b. Cit	, Town, or	Location o	f Death		4c. 0	County of Deat	h
			Deers Head Hosp Cen	ter			So	lista	ing m	8		Wi	COMICO)
	Funeral		5. Social Security Number 6. Set	7. Age	(In yrs.	last birthday)	If Und	er 1 Year	If Under 2 Hours		8. Date of Birtl (Month, Day	h V Year)	9. Birt	hplace (State or Foreign
	Director		218–16–5342]м 2🙀 ғ	89	Yrs.	MONTH	Days	Hours	IVINI.	12/26/	1917		ryland
	P .		Usual Residence of Decedent											_
	show	_	10a. State 10b. County			y, Town or Loc								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	8a-f	cto	Maryland Wicomic	.0	S	alisbu	сy							
	ith th	Director	10e. Street and Number				10f. Z	ip Code				10g. Citiz	en of What Co	ountry?
	23a	ra Ta	1016 Sherwood C	ircle				21804	ł				ISA	
	e de	Ine	11. Marital Status	12. Was Decedent 8 Armed Forces?		.S. 13. V	Vas Dec Yes, sp	edent of Hi ecify Cuba	ispanic Orig in, Mexican	gin? (Spe , Puerto P	cify Yes or No- Rican, etc.)	. 1	 Race - Ame Black, White 	
36	or if	ΥFI	1 Never Married 2 Married	1 ☐ Yes 2 🕱 N If Yes, Give	lo	1	☐ Yes	2 7 0	Specify:				Specify: wh	ite
21215-0036	within 72 hours after death with the Maryland ene. than "neturef", or items 23e or 28e-f show ha Madisal Exertiner must be notified at	Completed by Funeral	3 □xVidowed 4 □ Divorced	Year or Dates:										
7	"nat	lete	15. Decedent's Edu (Specify only highest grad	e completed)			kind of w	ork done o	during most	of working	ng	16b. Kin	d of Business/	industry
12	Mithir and the state of the sta	Ę	Elementary/Secondary (0-12)	College (1-4or 5	+)	Dieta	DO NOT use retired)				Sta	te of i	Maryland	
7	Tygie Ther nt, I	ပိ	17. Father's Name (First, Middle, Last)								(First, Middle,			act y tana
an	ntal d o	Be	Wilby Todd								a Ruark		,	
Maryland	d Me	2	19a. Informant's Name/Relationship (Ty	rna Printl		19h Mailin	a Addre	es (Stroot :	and Numbe	r or Rura	l Route Numbe	r City or	Town State	Zin Code)
<u>s</u>	d2s than 7 is 1		Willard Wayne Fie				-				Salish			
ص ص	1 an Heall em 2		20a. Method of Disposition		20b. F	Place of Dispos			1		ate		ation - City or	
٥	iges if it		1 Burial 2 Cremation 3 F		0	emetery, crem ringhi	atory or	other plac		c /5 /	05			
Ë	t. P.		4 Donation 5 Other (Specify)		DP	Card	219.0	_		6/7/			bron, I	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturat", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinat must be notified at an once.	21. Signature of Funeral Sovice Licensee 21. Signature of Funeral Sovice Licensee CFS P Gardens Holloway Funeral Home Professiona 501 Snow Hill Rd., Salisbury, MD												Association
		-	23a. Part1. Enter the disease, or compl	XV CL	SP		DOT	Snow	HITT	Ra.	Salis	bury	, MD 21	.804 Approximate
1			shock, or heart failure. List only of	e cause on each lin	10.	n. Do not ente	ar (rie) iri	O de or dylli	y, such as	Cardiac O	r respiratory ar	rest,		Interval Between Onset and Death
6.00	Physician		Immediate Cause (Final disease or condition resulting in death)	15051	200	170.TY	,	Lan	_(v.	e				
	/Medical Examiner		f	Due to (or as a	a conseq	uence of): (
194.0		-	Sequentially list conditions,	Due to (or as	LACE			<u> </u>						
	ed sslt	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	~ ~ ~	1 1	dence on.		.0						
_	and and	xan	that initiated events resulting in death) Last	Due to (or as	a consed	uence of):	0	TU	VIV	e.				
8760,	cate be executed physician and the burial-transit	al E				,								
387		dical		d										
×	death certifi e attending id for use as	by Physician/Me	IF FEMALE:	3c. If yes, outcome	of pregna	ancv						2	3d. Date of del	ii (OR)
Вох	atter for u	cian	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Feta	Ideath 3	Ectopic Other (pregnancy					Month	Day Year
o.	0 0 0	ysi	1 Yes 2 No 9 Unknown	9□ Unknown			,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
۵.	The law requires that the site has been signed by the bage 2 should be detached.	Ph	Part II. Other significant conditions con	ntributing to death bu	ut not res	ulting in the un	derlying	cause give	en in Part I.		23e. Did to	bacco us	e contribute to	the cause of death?
ds,	signe d be										1 🗆 Y	es 2	No 3□Pr	obably 4 Unknown
Ö	w requir been s should	Completed									04- 146-	/	0.4h 14/2-2-2-1	to a Carlos a salable
Ě	: The lav cate has	dm							-		24a. Was autop		prior to death?	itopsy findings available completion of cause of
e	, u											2 X No	1 🗆 Yes	2X No
Vital Record	ding Physician: Th h. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	or .		(Check only o			
7	Phys this at dii	၉	1 Yes 2 No	1 🗀 Inpatre		ER/Outpatien	3 🗆 [UA	4/20140		ne 5 Resid			cify)
Ë	ling I. After Tuner	o	1.⊠Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	Injury	M	28c. injury Work			8d. Describe h	iow injury	occurred	
Sign	Attending r death.	cat	2 Accident investigation 3 Suicide 6 Could not be	20a Blass of lais	As b	(Yes 2 1		194 Leasting (6		I Number of C	and Double Mumber
Division	or A	Certification:	4 Homicide determined	28e. Place of Inju- building, etc	Specif	y)	et, racto	ry, οπιce			City or Tou	vn, State)	INUITIDE OF AL	ural Route Number,
J	Hospital or Attend 24 hours after deatl Funeral Director: tely filled in by the		29a. Certifier Certifying Phy	eicien: To the heat	of my les-	vuladae dassh	000000	d at the t	no dota a-	d plans =	and due to the	20110-1-1		a at a t a d
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	Medical	(Check only 2 Medical Exami	sicien: To the best oner: On the basis of and manner sta	examina	tion and/or inv	estigation	n, in my of	pinion, deal	th occurre	ed at the time,	date and	place, and due	to the ceuse(s)
	within 2 To the complet	Me	29b. Signature and title of certifier	who maillet Sta			2	9c. License	e number			29d. Date	signed (Mont	h. Day, Year)
	- 3 - 8		10	,) .				,				11	11-	, ,
1	Sp) Vleu	acro	- al- //-	- 00-1 (7	/		686			6/9	1107	
`	10		30. Name and address of person who co	ompleted cause of de	eath (Iten	n 23a) (Type, I	rrint)	-	- FT	,	ry L	10	2	at
	Sta		357 Deer's He 31. Date filed (Month, Day, Year)	32. Registra	ar's Sign	n 23a) (1ype, 1 L Ro ature	Geal		dali	-6 h	xy cr	(0)	<u> </u>	50
	Registr		JUN 0 6 20	007	4-	ature H A	and.	,			,			

State of Maryland / Department of Health and Mental Hygiene

Funeral Director	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If item 27 is marked other then "natural; or terms 23a or 28a-1 ehow eny injury or other traumatic event, the Medical Examination must be notified at once.	To Be Completed by Funeral Director
Physician /Medical Examiner	ıer

		•	1 - State Registrar			Cert	ificate of l	Death		Reg. No	.			
	Dhamisi		1. Decedent's Name (First, Middle, L.		- 1 0		2 !		2. Date of D	eath Da	y Year_	3. Time of Death		
5	Physici /Medic		ELEANOR		ERG	us	50N		06	01	2007	12,504		
>	Examin		4a. Facility Name (If not institution, gi				4b. City, Town, or	Location of Death	1		. County of Death			
H			Mariner Health				Wheato:		R Date of Bi	Me	ontgomery	olace (State or Foreign		
	Funeral			Sex 7. Age 1 ☐ M 2 🖾 F	e (In yrs. last birti 91 Y	rs.	Months Days	Hours Min.	8. Date of Bi (Month, D Aug. 19	ay, Year)	915 New	York		
	Director		Usual Residence of Decedent	<u> </u>		Aug. 12	, 1	JIJ NEW_	TOTA					
	yland now		10a. State 10b. County		10c. City, Town	or Loc	ation					10d. Inside City Limits		
	Man Fire	to	NY Monroe		Ro	ches	ster					1⊠Yes 2□No		
	in the	Directo	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What Cou	ntry?		
	th will	aiD	34 Circle Wood	Road			146	25		U.S.				
	- dea	Funerai	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto			pecify Yes or N o Rican, etc.)	0-	14. Race - American Black, White,			
2	hours after death with the Maryland ture!; or ttems 23a or 28a-f ehow al Examirer must be notified at	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🛣 N	10						Specify: Afr	_{cify:} African American		
5-0036	72 hours after death with the Marylan "natural", or Items 23e or 28e-f ehow olcal Examirat must be notified at		3 X Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:	16a	Decede	ent's Usual Occup	ation		16b K	Kind of Business/In			
င်	within 72 ene. then "nat	Completed	(Specify only highest g	ade completed)		(Give k	ind of work done of NOT use retired	during most of wor.	king	100.1	Card of Dagarogan			
1717	with lene.	E	Elementary/Secondary (0-12)	College (1-4or 5		Social Worker Supervis			sor]	N.Y.C. Go	ov't.		
	Hygi other	BeC	17. Father's Name (First, Middle, Las					18. Mother's Nan						
a	should be nd Mental marked o	To B	John A. Ross					Gerald:	ine McD	ora				
Maryland	2 should and Men is marke sumatic	-	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing	Address (Street	and Number or Ru	ral Route Numi	ber, City	or Town, State, Zip	Code)		
	D E M =		Joseph F. Fergu	son, Jr. /	Son 10	04	Woodside	Parkway		r Sp	ring, MD	20910		
or e			20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3	Removal from State	20b. Place of cemeters	Dispos y, crema	ition (Name of atory or other place	(e)	Date	20c. L	ocation - City or To	own, State		
altimore,	Pages ment of ant: If it ury or o		`4 □Donation 5 □Other (Spec		Chesap						eltsville			
<u></u>	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Lice	nsee								ice, Inc.		
מ	20239		Undre o	nompso		_					ngton, D	.c. 20012		
3			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused y one cause on each lir	ithe death. Do n ne.	ot ente	r the mode of dyin	g, such as cardiad	or respiratory	arrest,		Approximate Interval Between Onset and Death		
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Dement:	ia									
	/Medical Examiner		resulting in dealth)	Due to (or as	a consequence of	of):								
		16	Sequentially list conditions,	b. Due to (or as	a consequence o	n1):				·				
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate causs. Enter Uncertains Cause (Disease or injury											
	executand al-tra	xar	that initiated events resulting in death) Last	c. Due to (or as a consequence of):										
68/60	certificate be executed ding physician and ise as the burial-transit			d										
200	ificati g phy as the	/Medical												
×			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Petal death	3 🗀	Ectopic pregnancy	,			23d. Date of deliv	,		
J.	death of attenued for u	Physiciar	in the past 12 months? 1 ☐ Yes 2 ☒ No	4☐Pregnant at 9☐Unknown			Other (specify)				Month	Day Year		
J.	law requires that the dei as been signed by the a 2 should be detached f	hys	9 Unknown						1	1				
	es th igned be de	b	Part II. Dther significant conditions	-	ut not resulting in	the un	derlying cause giv	en in Part 1.				the cause of death?		
ecords,	w require been sign	ted	Deep Venous Th	rombosis					11.	Yes 2	2 KUNO 3 [] FIO	bably 4 Unknown		
e C	law law las b	Completed	Renal Disease						24a. Wa aut	opsy	prior to co	opsy findings available empletion of cause of		
<u> </u>	The la	S	Congestive Hea	rt Failure						formed? 2X No	death?	2□ No		
Vital H	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		- W 10	Oth	26. Place of Dea	ath (Check only	one)				
0	hys this	5	1 Yes 2 No	28a. Date of Inju	4 7 7	tpatient ime of		4 EN HUISHIGT	lome 5 Res		6 ☐Other (Speci	fy)		
2	Jing After fune	ion	1 X Natural 5 ☐ Pending	(Month, Da	y Year) I	niury	28c. Injur Wor M 1	k? Yes 2 □ No	200. Describe	o now inju	ary occurred			
Division	deal deal ctor: , the	fica	3 ☐ Suicide 6 ☐ Could not	be 280 Place of Ini	ury - At home, la	rm, stre		_	281. Location	(Street a	and Number or Rur	al Route Number,		
2	P tfe o	Certification:	4 Homicide	building, et					City or To	own, Stat	te)			
	To the Hospitel within 24 hours a To the Funeral Completely filled			hysician: To the best										
	ne Ho 1 24 h Ne Fu iletely	edicai	(Check only 2 Medical Expone)	miner: On the basis o and manner st		d/or inv	estigation, in my o	pinion, death occu	irred at the time	e, date an	nd place, and due t	to the cause(s)		
ì	To the Hosp within 24 ho To the Func completely f	M	29b. Signature and title of certifier	0 ,	1		29c. Licens	e number		29d. Da	ate signed (Month,	Day, Year)		
1	1		- Klurus	a SW	temp		D56	5691		Jur	ne 1, 200)7		
1	O		30. Name and a dress of person wh	completed cause of c	leath (Ite 3a (Туре, Р	Print)							
			Ghousia Sultana			Vie	ers Mill	Road Sil	ver Spi	ring,	MD 2090	06		
	Sta	ite	31. Date filed (Month, Day, Year)	32) Registr	ar's Signature	-								

State Registrar

JUN 0 6 2007

			For State Registrar	State of Maryland	Department of H Certificate of I			ene g. No.	19893
	Physicia	an	1. Decedent's Name (First, Middle, Last) FDWAR	D F09	TER		2. Date of Death Month JUNE	8ªY , 2007	3. Time of Death 6:20 PM
	/Medic Examin		4a. Facility Name (If not institution, give str Hebrew Home of Grea	eet and number) ter Washingtor	4b. City, Town, or Rockvil	Location of Death		4c. County of Deat Montgome	
	Funeral Director		5. Social Security Number 6. Sex 190-05-2240 15kg N	7. Age (In yrs. last 99	r birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 3/27/08	Year) 9. Birt Co	hplace (State or Foreign funtry) Pa•
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	fown or Location				10d. Inside City Limits
	Mary B-f she	tor	Md. Montgomery	7 Ro	ckville				1 ☑ Yes 2 ☐ No
	th with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 6121 Montrose Rd	•	10f. Zip Code 20852			us. Citizen of What Co	
9036	s 1 end 2 should be filed within 72 hours after deeth with the Maryland I Health and Mental Hygiene. Item 27 ie marked other than "natural", or iteme 23a or 28e-f show other treumatic event, the Mudical Exam, ar must be notified at	by	11. Marital Status 12 1 □ Never Married 2 □ Married 3 ☎ Widowed 4 □ Divorced	. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (Spe in, Mexican, Puerto f Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
Maryland 21215-0036	within 72 h ane. than "natu na Wedical	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)		16a. Decedent's Usual Occup (Give kind of work done of iife. DO NOT use retired Sales	ation during most of workir 1))g	66. Kind of Business Hardware	Industry
d 2	2 should be filed within and Mental Hygiene. ie marked other than eumatic event, the Ma	Be Co	17. Father's Name (First, Middle, Last)		Sales	18. Mother's Name	(First, Middle, N	faiden Sumame)	
ylar	should be and Mental marked o	To B	Harry Foster				nknown		
Mar	nd 2 sho aith and 27 ie m	1	19a. Informant's Name/Relationship (Type Eila Amdur/daught		19b. Mailing Address (Street 14612 Bauer D				Zip Code)
	of Heali item 2 other	1 3	20a. Method of Disposition	20b. Plac	te of Disposition (Name of letery, crematory or other place			20c. Location - City or	Town, State
ë	Page ment o ant: if ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	ilovatitotti State	ean Memorial G		6/3/07_	Olney, Md	•
Baltimore,	permit. Pages. Depertment of H Important: if ite any injury or of		21. Signature of Funeral Service Licensee		22. Name and Addre Edward Sag 1091 Rockv	el Funera ille Pike	Rockvil	.le. Md20	0852
		9 4	23a. Part1. Enter the disease, or complications shock, or heert failure. List only one	tions that caused the death. cause on each line.	Do not enter the mode of dyir	ig, such as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequer	IVE HEAR		LUKE		
Н	Examiner		Sequentially list conditions. b.	PARKIN	50NS DIS	EASE			
	bed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequer	nce of):				
ó	cate be executed physician and the burial-transit	Exar	that initiated events c. resulting in death) Last	Due to (or as a consequer	nce of):				
68760,	ate be	dical	d.						
Box.	death certifi e ettending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. If yes, outcome of pregnanc 1□Live birth 2□Fetal de 4□Pregnant at time of deat 9□Unknown	eath 3 Ectopic pregnancy	/		23d. Date of de Month	livery Day Year
rds, P.O.	es the	۵	Part II. Other significant conditions control	nbuting to death but not resulti	ing in the underlying cause giv	ren in Part I.		es 2 to No 3 □ P	o the cause of death?
Il Records,		Completed					24a. Was an autops perform	v / prior to	utopsy findings available completion of cause of s 2 No
Vital	Physicien: this certific ral director.	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatient 3 DOA Ott	26. Place of Death		e) ince 6 □Other (Spe	aciful
of		H	27. Manner of Death 1 Natural 5 Pending		8b. Time of linjury Wor			w injury occurred	neny)
Division	Attending r death. ector: After by the fune	catle	2 Accident investigation 3 Suicide 6 Could not be		M 1 🗆	Yes 2□No	18f Location (St	reet and Number or R	ural Poute Number
D.	al or Attend s efter death d Director; d in by the f	Certification:	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, factory, onice		City or Towr		arai riodia valiloo,
	To the Hospital or vithin 24 hours efter To the Funerel Direction completely filled in the Funerel Completely filled in the Funerel	Medical C	29a. Certifier (Check only one) 1 Certifying Physical Cartifier 2 Medical Examina	cian: To the best of my knowledge. On the basis of examination and manner stated.	n and/or investigation, in my o	ppinion, death occurr	ed at the time, da	ate and place, and du	e to the cause(s)
)	To ti To ti comp	W	29b. Signature and the of certifier	e Lollery	y MD. D	35436	2	9d. Date signed (Mon YUNE 02	th, Day, Year) 2, 2007 HD 20852
			30. Name and address of person who con BANA A A A A A A 31. Date filed (Month, Day, Year)	ALNYM.D.		TOSE RI	AD, RA	CHVILLE	KD 20852
1	Sta Regist		JUN 0 5 2007	32 Registrar's Signatur	Goeste				

nd 10a		1 - State Registrar per FR/wichd/6-6-07/dls 1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of De		3. Time of Death					
Physicia		Juan Yindo Guevara		Month 6		0445a					
/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County o	_					
d,		SGAH	Rockville	8. Date of Bir		tgomery					
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth $445-50-1032$ $X^{\square M}$ $2^{\square F}$ 59	Months Days Hours Min.	8. Date of Bit (Month, Da	24747	Birthplace (State or Foreign Country) Panama					
			Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limit				
natural", or items 23a or 28a-f show dical Examiner must be notified at	ō	<u>, MD</u>				1∭Yes 2□N					
. 28a- notifi	Director	Montgomery Damaso	US 10f. Zip Code		10g. Citizen of W	hat Country?					
23a ol ist be		25262 Conrad Court	20872		USA						
ital Hyglene. sd other than "natural" or items 23a event, the Medical Examiner must b	y Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ X Yes 2 □ No Army If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 X Yes 2 □ No Specify: Par		o- 14. Race Black Specify:	- American Indian, , White, etc. Hispanic					
in "natural Medical Ex	Completed by	15. Decedent's Education 16a.	Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired)	king	16b. Kind of Bus	siness/Industry					
riygiene other tha ent, the	Com	12 4	Salesman	Salesman							
d oth	Be	17. Father's Name (First, Middle, Last)			e, Maiden Surname						
for nealth and mental If item 27 is marked o or other traumatic eve	၉	Juan Guevara 19a. Informant's Name/Relationship (Type. Print) 19b.	Mailing Address (Street and Number or Ru.		Hernandes ber, City or Town, S						
reall al			town, MD	20876							
item r othe	ŀ	20a. Method of Disposition 20b. Place of	Disposition (Name of crematory or other place)	Date		City or Town, State					
ant: If ite ury or o		4 Donation 5 Other (Specify) MD VA Cemetery 6/7/07 Hurlock, MD									
Department of Important; If any injury or once.		21. Signature of Funeral Service Licenses	22. Name and Address of Facility Be 917 W. Isabella St	nnie Sm . Salis	ith Fune: bury, MD	ral Home 21801					
ysician		23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumatosis I		or respiratory a	arrest,	Approximate Interval Between Onset and Death 12 Hours					
/ledical aminer		Due to (or as a consequence of Cirrhosis):			Months					
6 5	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	b Due to (or as a consequence of):								
physician and s the burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of				Years					
signed by the attending phy I be detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date Mor	e of delivery hth Day Year					
ned b e deta		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did	tobacco use contri	bute to the cause of death?					
been sig should b	ed b	Acute Hemorrhage		1 🗆	Yes 2□No	3 ☐ Probably 4 ☑Unknow					
2 88	Completed by	Acute Anemia Coagulopathy		perl	opsy p formed? d	Vere autopsy findings availat rior to completion of cause o eath? □Yes 2⊶No					
certificate harector, page	Be C	25. Was case referred to medical	26. Place of Dea	1 Yes th (Check only							
.≌ '등	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Out	· · · · · · · · · · · · · · · · · · ·	ome 5 Res	sidence 6 □Othe	er (Specify)					
offer unera	Certification:	27. Manner of Death 1	ury Work? M 1 ☐ Yes 2 ☐ No	28f. Location	e how injury occurre (Street and Numbe	ed er or Rural Route Number,					
within 24 hours are death. To the Funeral Director A completely filled in by the fu	Medical Cer	29a. Certifier (Check only one) One) 29a. Certifying Physician: To the best of my knowledge 2□ Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place /or investigation, in my opinion, death occu	e, and due to the arred at the time	e cause(s) and ma e, date and place, a	nner as stated. and due to the cause(s)					
To the	Me	29b. Signature and title of confiler	29c. License number		29d. Date signed	(Month, Day, Year)					
AD.		141	58681		6/4/0	7					
JONA		30. Name and rest of Person with completed cause of death (Item 23a) (June Alexander Shady Grove Hosp: 31. Date filled (Month, Day, Year) 32. Registrar's Signature		yland 2							

State

Registrar

JUN 0 6 2007

		For 1 State	State of Ma		d / Depa		Health an	d Mental Hy	/giene	Jibie.		
Physici /Medic		Registrar Decedent's Name (First, Middle, Lass WILLIAM EDWARD GA				imodio or	Deam	2. Date of Domestin	1109.110.	Year 2007	3. Time of Death 11:45 AM	
Examir		4a. Facility Name (If not institution, give				4b. City, Town, o	or Location of D		4c. Coun	ty of Death		
		ANNE ARUNDEL MEDIC		- (In	for each for limited and an all	ANNAPOL If Under 1 Year		Hrs. 8. Date of Bi		ARUNI		
Funeral Director		5. Social Security Number 6. S 218–16–8341	ex 7.Ag MX 2□F	82	last birthday) Yrs.	Months Days		Vin. (Month, D	run Pay, Year) R 21 , 192	Cou		
untilliplace of the fifty of		Usual Residence of Decedent						DIXATRA	. 21, 172			
farylan show ed at	'n	10a. State 10b. County	_	10c. City	y, Town or Lo	cation			10d. Inside City Lim 1 ☐ Yes 2 🔣			
the M 28a-f notifie	Director	MARYLAND QUEEN AN 10e. Street and Number	NE'S	CHES	TER	10f. Zip Code			10g. Citizen o	f What Cou		
d 2 should be filed within 72 hours after death with the Maryland d 2 should be filed within 72 hours after death with the Maryland Hand Mental Hygiene. 77 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at		2608 COX NECK ROAL)			21619				UNITED STATES		
ems 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.		Hispanic Origin	? (Specify Yes or Note of Rican, etc.)		ace - Ameri	can Indian,	
s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 【Widowed 4 ☐ Divorced	1 □ Yes 2 😿 I If Yes, Give Year or Dates:	No		1 ☐ Yes 2 👿 No		,		ify: WH]		
thour salex					16a. Dece	dent's Usual Occup	pation		16b. Kind of	Business/In	dustry	
thin 72 e. an "na Medic	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5	5+)	(Give life. i	kind of work done DO NOT use retire	during most of d)	working			,	
filed within Hygiene. Ither than "	Con	12			FARME	R			AGRICU			
t be fill had a ha	Be	17. Father's Name (First, Middle, Last)						Name (First, Middle				
should be and Mental marked o	L C	OREM AQUILA GARDN 19a. Informant's Name/Relationship (7)			19b. Mailir	ng Address (Street		ADALINE B or Rural Route Numl			Code)	
C = W F		DEBBIE GARDNER/DAI						CHESTER,			,	
860-1		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of matory or other pla		JUNE 9,	20c. Location			
Pages ment of ant: If its ury or o		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (<i>Specify</i>	1)	STE		LLE CEME		2007			, MARYLAND	
permit. Page Department of Important: If any injury or		21. Signature of Bunaral Service Licen	See /	U	FE 10	LLOWS, H	ess of Facility ELFENBE CK ROAD	IN AND NE	WNAM FU	NERAL	HOME, P.A	
Physician /Medical Examiner partial-transit pa	ical Examiner	23a. Part1. Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
The law requires that the death certificate the has been signed by the attending phys age 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy Month 5 □ Other (specify)									ery Day Year	
w requires that the d been signed by the should be detached	by	Part II. Other significant conditions of	ontributing to death b	ut not resu	ulting in the u	nderlying cause giv	ven in Part I.		tobacco use co Yes 2 No		he cause of death?	
The law reate has bee	Completed							24a. Was auto perf 1 Yes	opsy ormed2	o. Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of	
Physician: The rhis certificate Iral director, pag	Be C	25. Was case referred to medical examiner?					26. Place of	Death (Check only	-	1 1 1 1 1 1 1		
Attending Physician: r death. ector: After this certific by the funeral director,	은	1 ☐ Yes 2☐ AR	Hospital:		ER/Outpatien		4 LIVUISII	ng Home 5 □ Res			fy)	
ng ine	ion:	27. Manner of Death Towatural 5 Pending 2.17. Accident investigation	28a. Da f e of Inju (Month, Daj		28b. Time of Injury	Wor	ryat rk?]Yes 2∐No	28d. Describe	how injury occu	urred		
Atten death ctor:	ficat	3 Suicide 6 Could not be	28e. Place of inju			eet, factory, office		28f. Location	(Street and Nun	nber or Run	al Route Number,	
al or safter	Certification:	4 ☐ Homicide determined	building, et	c. (Specify	y)			City or To	iwn, State)			
To the Hospital or Attendi within 24 hours after death. To the Funeral Director; a completely filled in by the fu	Medical (29a. Certifler (Check only one)	ysician: To the best niner: On the basis of and manner sta	f examina	wledge, deatl tion and/or in	n occurred at the ti vestigation, in my	ime, date and p opinion, death	place, and due to the occurred at the time	e cause(s) and r e, date and place	manner as s e, and due t	stated. o the cause(s)	
withir To th comp	Me	29b. Signature and Ittle of certifier				29c. Licens	se number	. /	29d. Date sign	O A Pro	Day, Year)	
198		16 4/	A1			14/4_	3577	4	0/6/2	00>		
15		SAVEN K	completed cause of d	eath (Item	23a) (Type,	Print) L	nine	le Mer	Pical	Cent	en	
Sta Registr		31. Date filed (Month, Day, Year) JUN 0 8	2007 32. Registra	ar's Signa	ture	from A						

DHMH 17 Rev 1/2001

				State of Marylan		irtment of <i>tificate o</i>			iene og. No.	j	989	
	Physici	an	Decedent's Name (First, Middle, L Mar		Green			2. Dete of Deet Month 6 / 4 / 2 0		Year	3. Time of Death 2:08PM	
	/Medic		4a Facility Name (If not institution, gi		OI CCII		4b. City, Town, or I		4c. County of	Death	2.00111	-
	Examin Funeral Director	er	13201 Hedgero 5. Sociel Security Number 6.	•		if Under 1 Yes	Upper Ma ar If Under 24 Hrs.		Princ	e Ge	eorge's ce (State or Fore Ington	eian
	D .		Usual Residence of Decedent					1 - 7 - 7		40	1 1-11 02 11	-,
	show show	٦	DC 10b. County		y, Town or Loc ingto:					100	d. Inside City Lim XIXYes 2 □ i	
	the N	ecto	10e. Street end Number	Wasi	Ting co.	10f. Zip Code		11	0g. Citizen of Wh	nat Countr	v?	
	3a or		1516 Gallatin	Place NE	Place NE 20017						,-	
Baltimore, Maryland 21215-0036	n 72 hours after death with the Maryland "natural", or items 23s or 28s-f show adical Examiner must be notified at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of Yes, specify Cu	f Hispanic Origin? (Suban, Mexican, Puerto o Specify:	pecify Yes or No- o Rican, etc.)	Black,	Americar White, etc Blac	c.	
5	72 h	etec	15. Decedent's E (Specify only highest gr	ducation rede completed)	16a. Deced (Give I	ent's Usual Occ kind of work dor	upetion ne during most of wor. red)	king	16b. Kind of Bus	ness/Indu	stry	
121		du.	Elementery/Secondary (0-12)	College (1-4or 5+)		<i>00 NOT</i> us <i>e reti</i> Ousewi			Domest	E 2 -		
d 2	should be filed within nd Martal Hygiane. marked other than "		17. Fether's Neme (First, Middle, Las	t)	п	Dusewi		ne (First, Middle, M				
au	d be antal	To Be	Frank Bell	,			Elanor	, , ,				
ary			19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	g Address (Stre	et and Number or Ru		City or Town, S	tate, Zip C	ode)	
Σ.	es 1 and 2 and 2 and 1 a		Jeffery Green,				tin Pl N	E Washi	ngton	DC 2	:0017	
ore	ges 1 if of He if Itam or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [sition (Neme of netory or other p			20c. Location - C	•		
Ë	@ E :: >		4 □ Donation 5 ☑ Other (Speci	fy) / FT			metery 6					
Bal	permit. Par Departmen Important: any injury once.		21. Signature of Fon and Service Lice	Taylor)			ress of Facility T rth Capi	aylors tal St				
			23e. Part1. Enter the disease, or con shock, or heart feilure. List only	nplications that caused the deet	h. Do not ente	er tha mode of d	ying, such as cardiac	or respiratory erre	est,	i Ir	Approximate nterval Between	
	Physician /wegicar Examiner		Immediate Cause (Final disease or condition resulting in death)		Onset and Death							
		ē		Due to (c	or as a consequ	uence of):				1		
oʻ	ficate be axecuted physician and is the bural-transit	il Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	b. Due to (o	r as a consequ	uence of):				1		
ς 68760,		Medical	Cause (Disease or injury that initiated events resulting in death) Last		ras a consequ	ienca of):						
Вох	aath certifi attanding for use as	an		d								
	the a	Physician/M	Part II. Other significant conditions		ulting in the un	derlying cause	given in Part I.		bacco use conti			
, P.O	that the da		Chronic Renal	Failure				1 🗆 Ye	es ≱∰No 3	∃ □ Proba	ibly 4 Unkn	own
of Vital Records,	E G	Completed by						24a. Wes er perform		avail	e autopsy finding lable prior to pletion of cause eath?	js
al F	: Tha la cata ha r, page							t⊡Ye	# 2 CM 0	1 🗆 '	Yes 2□ No	
X;		Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ED/Outpations	2 DOA C	Wher:	th (Check only on		/C#-	Daughter's	5
	ding Physith. After this funeral di	tlon: To	27. Manner of Death 1XIXatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. In	4 Li Nursing H	ome 5 ☐ Reside 28d. Describe ho			Residence	
Division	al or Attending safter death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not to determined	286. Piece of injury - At no	28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street City or Town, St.						Route Number,	
	To the Hospital of within 24 hours aft To the Funeral Di completely filled in	edical		nysician: To the best of my kno miner: On the basis of examine and manner steted.								
	withir To th	ž	29b. Signature and title of contifier	. // /			nse number		9d. Date signed		ay, Year)	
			14/	/ fall	MO) D00	3752 (M	1D) 6	5/7/200	7		
)	(1)		30. Neme and eddress of person who									
			Ronald Wheeler 31. Date filed (Month, Dey, Year)	MD 1221 Me	ercant	ile La	ne Upper	Marlbo	ro Md	2077	4	
	Stat Registra		IIIN 0 8 2007	32. Registrar's Signe	que							

DHMH 16 Rev 6/95

Examiner law requires that the death certificate be executed and the burial-tra Division or Vital Records, P.O. Box 68760, physician as esn for þ signed b page 2 certificate Physician: funeral director, this After Attending within 24 hours after death To the Funeral Director:

Physician

/Medical

Examiner

Funeral

Director

a or 28a-f show t be notified at

iral", or items 23a Examiner must b

'natural",

if Health and Mental Hygiene. Item 27 Is marked other than "natul other traumatic event, the Medical

in and 2 should be file. Health and Mental History tem 27 Is marked oth

.. Pages 1 an...ment of Health an

permit. Page: Department or Important; If I any injury or

Physician

/Medical

Director

Funeral

Be Completed by

၀

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician/Medical Examiner Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 25. Was case referred to medical examiner? Be 1 ☐ Yes 2 No 27. Manner of Death Certification: To 28c. Injury at Work? 1 Natural 2 ☐ Accident (Month, Day Year) Injun 5 Pending investigation M 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

completely

ò

filled in by

31. Date filed (Month, Day,

7503 Surratts RD clinton 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - State Registrar			Cert	ificate of L	Death		Reg. I	No.		
6	Physici	an.	1. Decedent's Name (First, Middle, Last)						2. Date of I		Jav	Year	3. Time of Death
	Physici /Medio		WILLIAM ALLEN GIDI	INGS, Sr.					June	1,	2007		11:40p M
à	Examir	er	4a. Facility Name (If not institution, give str	eet and number)			4b. City, Town, or	Location of D	eath		4c. County of	of Death	
			Washington Adventi			th day)	Takoma If Under 1 Year	a Park	Hre To Date of F	Ni mella	Monte		·
Ì	Funeral Director		-	//. Age (//	n yrs. last birt		Months Days		Min. 8. Date of E (Month, I 05-15	Day, Yea	1 <i>r</i>) 29	9. Birthpl Coun Mary	
	yland low at		10a. State 10b. County	10	c. City, Town	or Loca	ition					10	0d. Inside City Limits
	Mar.	ţoţ	Maryland Prince Ge	orge's	Belts	v111	e						1 XYes 2 No
	th the	Directo	10e. Street and Number				10f. Zip Code			10g. (Citizen of W	hat Coun	try?
	th wi		11615 35th Avenue				20705			υ.	.S.A.		
9	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	/ Funeral	1 □ Never Married 2 🕅 Married	. Was Decedent Eve Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give	1956-		as Decedent of Hi ∕es, specify Cuba ⊇Yes 2⊠No	spanic Origin in, Mexican, P	? (Specify Yes or I ruerto Rican, etc.)	No-	Black	- America k, White, e	etc.
5-0036	hours ural";	d by	3 Widowed 4 Divorced	Year or Dates:	1963					1	Specify:	WILL	
	n 72 l "nat	Completed	15. Decedent's Educa (Specify only highest grade of	tion completed)	16a.	(Give ki	nt's Usual Occupa nd of work done o NOT use retired	ation Juring most of	working	7.1	Kind of Bus		ustry
2121	within iene. than "ithe Med	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)			Operato				illage ımp Li		c
	filed Hygi other ent, tl	Be C	17. Father's Name (First, Middle, Last)		1 0		орегисо		Name (First, Midd				<u> </u>
<u>a</u>	ould be Mental arked o	To B	George B. Giddings	:				Euger	nia T. Bu	rka			
Maryland	2 should and Men is marke aumatic	-	19a. Informant's Name/Relationship (Type		19b.	Mailing	Address (Street a		r Rural Route Nun		y or Town, §	State, Zip	Code)
	s 1 and 2 should by f Health and Ments tem 27 is marked other traumatic events		Kathleen Giddings			615	_35th Av	zenue,	Beltsvil	1e,	Marv1	and	20705
ore-	ges 1 t of Hk If iten or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer	noval from State	20b. Place of cemeter	Disposit y, crema	ion (Name of tory or other place	e)	Date		Location - 0		
Ĕ	Pa In:		4 Donation 5 Other (Specify)	ioval IIom State	St. Jo	hn's	s Cemete	ry 0	6-08-2007	Be.	ltsvil	lle,	Maryland
Baltimore,	permit. Departn Importa any Inju		21. Signature of Euneral Service Licensee	/ A .	-1-0		Name and Addres	•			4739	Balt	imore Ave.
_	<u> </u>		delevillent	D 7701	375				Home, P.		Hyatt	svi <u>l</u>	le, MD 2078
			23a. Part1. Enter the disease, or ombica shock, or heart failure. List only one	cause on each line.							_		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	CONG			HEA	727	FAIL	1721	٠,		Onset and Death
	/Medical Examiner			Due to (or as a co	onsequence o	BRS	TRUCT	IVE	PULMO	NE	my	Dr	E1155
	SICK!	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	onsequence o	£).						24.	enc
	cuted id ansit	Examiner	Cause (Disease or injury that initiated events	15 cthe	MIC		CAMPO	NUMI	4 opn-	(VI)	1 '		
Ď,	e execan an an arial-tr	Ex	resulting in death) Last	Due to (or as a co	nse uence	92	NIA	E Van	URE	-			
98/60	certificate be executed ding physician and se as the burial-transit	/Medical	d	700 (6		IOTIC	F 111					
ž X	ertific ling p e as t	Mec	IF FEMALE:						-				
O. BO	e death c	Physician/	in the past-12 months?	. If yes, outcome pf p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death		ctopic pregnancy other (specify)				23d. Date Mon		ry Day Year
7.	d by letack		9 ☐ Unknown Part II. Other significant conditions contri	buting to death but no	at reculting in	the und	arlying course give	n in Bort I	22a Dia	Ltabass	comeri	b 4 - 4b	e cause of death?
as,	signe d be c	by	PERIPHERA	T VA	3CIM	-AV	2 0	EAST	5				ably 4 Unknown
Ö	v requ	etec	DIABETET		117		1				_		
vital Records,	has ge 2 g	Completed	01111111	1 (00		0 -			24a. Wa	s an opsy formed?	pr	ere autop ior to com ath?	sy findings available pletion of cause of
TO.	n: Th ficate or, pa		OF Was soon referred to medical						1 Yes	200	No 1	Yes	ŽNo
5	sicfa certi irecto	Be	25. Was case referred to medical examiner?	spital:	2 T E B/Out	nationt	2 DOA Othe	-	Death (Check only				
ō	g Phy er this eral d	2	27. Manner of Death	28a. Date of Injury	2 ER/Outp	ime of	28c. Injury Work		g Home 5 ☐ Re 28d. Describe)
0	nding th. r; Afte e fun	T io	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ear) In	ijury		? /es 2 □ No					
IVISION	er dea ecto	Hice	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - building, etc. (S	At home, fari	m, stree	t, factory, office		28f. Location	(Street	and Numbe	r or Rural	Route Number,
5	ital or rs after all or rs after all Di	Certification:											
	To the Hospital or Attending Physiclan: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atten completely filled in by the funeral director, page 2 should be detached for u	Medical	29a. Certifier X Certifying Physic (Check only one) 2 ☐ Medical Examine	ian: To the best of m r: On the basis of exa and manner stated	amination and	death o	ccurred at the timestigation, in my op	ne, date and p pinion, death o	lace, and due to the	e cause e, date a	(s) and man ind place, a	ner as stand and due to	ated. the cause(s)
	With Com	Σ	29b. Signature and title of certifier	m			29c. License	number 1281	1 .	29d. [pate signed	Month, E	Day, Year)
R	(5) 1kg		30. Name and address of person who com	pleted cause of death	(Item 23a) (T	Type, Pri	nt) G70N	ADVE	en 107	1408	P, 7	AKA	OMARAR

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Y

MD-200112

			Pleas	e Type or Prir						•		9		
			For State	State of Ma	aryland					d Mental H	ygien	е		
			State Registrar 1. Decedent's Name (First, Middle,	(not)		C	ertifica	te of i	Death	2. Date of I	Reg. N	0.	, a Tie	ne of Death
	Physici /Medio		LEONA	MOF	GA	RDA	VER.			Month JUNE	D	ay Yea	r	342 AM
	Examir Funeral Director			inty Mospi	b e (In yrs. la	as <i>t birthda</i> 73 ^{Yrs.}	HA	PS To Ti Year	Location of Do		Birth Day, Year	7)	ator) ate or Foreign
	/land		10a. State 10b. County		10c. City	, Town or	Location						10d. Insid	de City Limits
	a-f sh	ctor	Maryland Washi	ngton	На	agers	town						1 🔯	Yes 2 □ No
	with th	Funeral Directo	10e. Street and Number					p Code				itizen of What	Country?	
	eath v	eral	35 East Frank1	12. Was Decedent	Ever in U.S	3. 13		21740		(Specify Yes or N		USA 14. Race - Ar	nerican India	n.
21215-0036	pormit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	Armed Forces?			If Yes, sp		Specify:	? (Specify Yes or I uerto Rican, etc.)		Black, Wi		
5-0	"natu edical	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Dec	cedent's Us	ual Occup	ation during most of f)	working	16b. I	Kind of Busines	ss/Industry	
212	y within jiene.	omp	Elementary/Secondary (0-12) 12	College (1-4or 5	5+)		omemal		,		D	omestic	2	
	e filec al Hyg d othe	Be C	17. Father's Name (First, Middle, Li	ast)	•					Name (First, Midd		n Surname)		
yla	d Menidanarke	To Be	Ray Kline	(Time Brief)		105.14-	lline Adden	(64		Viola R			~ ~	
Maryland	nd 2 shallth and 27 is r		19a. Informant's Name/Relationship Rhoda M. Stoteli		er	1	-			r Rural Route Nun onsboro ,				
	ss 1 ar of Hea ltem		20a. Method of Disposition				position (Na rematory or			Date		ocation - City		te
Baltimore,	Page ment ant: If		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		ŀ	st Ha	ven C	emete	ry 6	/13/2007		gerstow		
Ball	Depart Depart Intport any in		21. Signature of Funeral Service Li	censee						Rest Have a Avenue			-	
-57			23a. Part1. Enlor the disease, or	omplications that caused	the death				-			gerstow	Approx	
	Physician		shock, or heart failure. List or Immediate Cause (Final disease or condition	0	Totor	a L	DC:A	515					Onset	and Death
	/Medical Examiner		resulting in death)	Due to (o) as	a consequ	ence of):	· /	1 2						
	* Q.	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. ONO Due to (or as	a consequ	ence of):	Drl -	10110	eQ.					
	cuted nd ransit	Examiner	that initiated events	С										
60,	be executed ician and burial-transit		resulting in death) Last	Due to (or as	a consequ	ence of):								
		adica		d										
P.O. Box 687	The law requires that the death certificate bate has been signed by the attending physic age 2 should be detached for use as the bate.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 🗌 Fetal	death 3	B⊟Ectopic 5⊟ Other (s					23d. Date of o Month	delivery Day	Year
	s that med by e deta	by Ph	Part II. Other significant condition	s contributing to death b	ut not resul	Iting in the	underlying	cause giv	en in Part I.	23e. Dio	l tobacco	use contribute	to the cause	e of death?
ord	equire	ted k	Widdy Melast	offic Broos	Low	CE	With	Pleur	pl offus	51aus 10] Yes	2No 3□	Probably	4 □Unknown
Division or Vital Records,	2 38 2	Completed						(topsy formed?	prior t death	o completion	
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner	Hoopital				Oth		Death (Check onl)			1	·
o	Physic ruthis caral direction	٠ <u>۲</u>	1 ☐ Yes No 27. Manner of Death	Hospital: Inpatie		R/Outpati 28b. Time	ent 3 D		4 LI NUISIN	g Home 5 ☐ Re			pecify)	
lon	nding Fath. r: After e funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day	y Year)	Injury	′ м	28c. Injur Worl 1 □	k? Yes 2 □ No		,			
Divis	al or Atte t after dez il Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could no determin				street, facto	ry, office			(Street a	and Number or te)	Rural Route	Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the best xaminer: On the basis o and manner sta	f examinati	vledge, de ion and/or	ath occurre investigation	d at the tir	ne, date and pl pinion, death o	lace, and due to the	e, date a	s) and manner nd place, and c	as stated. lue to the ca	use(s)
	To the vithin To the comp	M	29b. Signature and title of certifier	7			25	c. Licens	e number	,	29d. D	ate signed (Mo	onth, Day, Ye	ar)
			· /////503	Sta M		00-1-7	PC	105	5071	/	0	///	0/	
			30. Name and address of person w	onst. Hos	395 br	NN,	MO c	9170	10			/		
ļ	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 9 200	32. Registr	ar's Signat	door.	2)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month HANCOCK NORMAN JUNE 2327 M 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Jown, or Location of Death 4c. County of Death **Examiner** BATTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER Baltimore City If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
DEC. 28,1943 5. Social Security Numbe 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 63 DÈC. Director Washington, DC 220-40-4758 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at show 1 ☐ Yes 2 No Director Carroll Maryland Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 6620 Wind Ridge Rd. 21771 States United illed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X)Yes 2□ No If Yes, Give Year or Dates: Vietnam 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🛣 No à Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Letter Carrier U.S. Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is 1 and 2 should be find Health and Mental Hitem 27 is marked oth Be Milton August Hancock Jeane Baeschlin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6620 Wind Ridge Rd. / Mount Airy, MD Marilyn F. Hancock / Wife permit. Pages 1 an Department of Healt Important; If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Pine Grove Cemetery 06/08/2007 Mount Airy, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home, 8 E. Ridgeville Blvd./ Mount Airy, MD 21771 21. Signature of Funeral Service License 23a. Part1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Immediate ause (Final Physician SEP515 MONTH /Medical resulting in death) Due to (or as a consequence of): Examiner SOPHAGEAL CANCER YEMR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): death certificate be executed burial-transi Exam and Due to (or as a consequence of): attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate 1 Yes 2 10 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA P this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death.
To the Funeral Director; After t Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

P.O. Box 68760, Division or Vital Records,

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

2007 ▶

29c. License number

BATTIMORE, MO

29d. Date signed (Month, Day, Year)

07-04425 Michael John Hart

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

nysicia								Death					Reg. No				
		Registrar 1. Decedent's Name (First, Midd									2	2. Date of D Month	Day	Yea		3. Time of De 1840 hrs	
Examir		Michae			Hart			0': T-		tif	Dooth	June 9,		c. County o	of Death	10101110	
		4a. Facility Name (if not institution 410 Wyoming Avenue		treet and nu	ımber)		41	b. City, Tov Hagers		cation of				Washing	gton		
neral	T	5. Social Security Number	6. Sex			rs. last birtho	day)	If Under Months	1 Year Days	If Under Hours	24Hrs. Min.	1	-		Foreign	hplace (State n Washi	or ngtoi
ector	L	227-17-9358	1 ^X M	2F	37		Yrs.					May	12,	1970	Cot	untry)	
ý	-	Usual Residence of Decedent 10a. State 10b. County			10c. 0	City, Town or	r Locatio	on							T	10d. Inside C	ity Limits
or 28a-f show any fird at once			ningt	on	ļ	На	oere	stown								1 X Yes	2 No
8a-fsl at onc	흸	10e. Street and Number	iringt	.011			J	10f. Zip C	ode				10g. C	tizen of Wh	hat Coun	ntry?	
23a or 28a-f sho notified at once	Director	413 Wyoming	Aven	nue				2	1740)				U.S.			
ms 23a be noti	uneral	11. Marital Status		2. Was De	cedent Ever i	in U.S.	13. Was	Decedent es, specify	of Hispa Cuban, N	anic Origi Mexican,	n? (Spe Puerto F	ecify Yes or Rican, etc.)	No-		e - Ameri e, etc.	can Indian, Bla	ack,
or ite	Fun		Married	1 Yes	2 X N	lo		Yes 2						Specify:	Wh	ite	
niner	ò	Widowed 4 Di 15. Decedent's Education (Sp	0	Yes, Give Yes		d) 16a. D		's Usual O			ind of we	ork done	16b	. Kind of Bu			
nt of Health and Mental Hygiene. 1: If item 27 is marked other than "natural", other traumatic event, th. M. di at Examiner.	ted	Elementary/Secondary (0-12			1-4 or 5+)			st of worki									
than dital	Completed			1			Elec	ctric							ctri	cal	
lygter other	3	17. Father's Name (First, Middle		77					18					n Surname	9)		
ental h rrked vent,	8	Michael Ter		Hart		1405	Adailina	Addross	/Ctroot			. Gra			wn State	e, Zip Code)	
is ma	٤	19a. Informant's Name/Relation Anne M. Stokes														land 2	0850
ealth a	H	20a. Method of Disposition	-	- Io the I		20b. Place of	f Disposi	ition (Name				Date				Town, State	
t of H		1 Burial 2 X Cremation		Removal f	from State			nerplace) tan C	roma	tori	11m f	6/12/		lexan	dria	ı, Virg	inia
Department of Important:		4 Donation 5 Other 3	Specify:	e C		hetrop							_	unera			11114
Depa In in	- 1	Kovest.	. /	Ville	um	>	1264	401 R	idoe	Roa	d. I	Damas	CHS.	Marv	land	me L 2087	2
sician		23a. Part I. Enter the disease, of	or complic	ations that	caused the d	leath. Do not	t enter th	ne mode of	dying, s	uch as ca	ardiac or	respirator	y arrest, s	hock, or he	eart	Approxima Between C	Inset and
dical		failure. List only one cause Immediate Cause (Final disease			broncho	pneumon	nia				1					De	ath
miner		or condition resulting in death)		ue to (or as	a consequer	nce of):											
		Commentally list conditions	b.													1	
	늘	Sequentially list conditions,	Di	ue to (or as	a consequer	nce of):											
	niner	if any, leading to immediate cause. Friter Uncertying Cause	C.		a consequer												
ısit	Examiner	if any, leading to immediate	e c.		a consequer												
an and al - transit	cal Examiner	if any, leading to immediate cause. From Uncerthing Cause (Disease or injury that initiated events resulting in death). Last	t C	ue to (or as	a consequer	nce of):	<i>(0</i>)	r /o., m									
E - E		if any, leading to immediate cause. Enter Unantifue Cause (Disease or injury that initiated events resulting in death) Last	t C	AMENDED	a consequer	nce of): L, g868,	, 6/2	5/07 T	Γ					23d. Date c	of deliver	ry	
E - E	/Medical	if any, leading to immediate cause. Finer Unantying Cause (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in	t Di	AMENDED #23a, 2 23c. If yes	a consequer 7, perMF , outcome of birth	nce of): 2, g868, pregnancy	Fe	tal death	3	Ectopio	pregna	incy		23d. Date o Month		Ty Day	Year
- a	sician/Medical	if any, leading to immediate cause. Fifther the arriving Cause (Disease or injury that initiated events resulting in death). Last VINPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months?	t Di	AMENDED #23a, 2 23c. If yes 1 Live 4 Pres	a consequer 7, perMF, outcome of birth gnant at time	nce of): 2, <u>g868</u> , pregnancy	Fe		3	Ectopic	c pregna	incy	_			-	Year
E - E	sician/Medical	if any, leading to immediate cause. Find the arrivation (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U	t Di	AMENDED #23a, 2 23c. If yes 1 Live 4 Preg 9 Unk	a consequer 7, perMF, outcome of birth gnant at time nown	2, g868, pregnancy of death $\frac{2}{5}$	Fe Ot	tal death ther (Spec	3 [fy)			23e.	Did tobac	Month	tribute to	Day the cause of	death?
E - E	by Physician/Medical	if any, leading to immediate curse. First Unarrying Care (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months?	t Di	AMENDED #23a, 2 23c. If yes 1 Live 4 Preg 9 Unk	a consequer 7, perMF, outcome of birth gnant at time nown	2, g868, pregnancy of death $\frac{2}{5}$	Fe Ot	tal death ther (Spec	3 [fy)			23e.	Did tobac	Month	tribute to	Day	death?
E - E	by Physician/Medical	if any, leading to immediate cause. Find the arrivation (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U	t Di	AMENDED #23a, 2 23c. If yes 1 Live 4 Preg 9 Unk	a consequer 7, perMF, outcome of birth gnant at time nown	2, g868, pregnancy of death $\frac{2}{5}$	Fe Ot	tal death ther (Spec	3 [fy)			23e. l	Oid tobace Yes 2	Month	tribute to	Day the cause of	death? Unknown s available
a a	by Physician/Medical	if any, leading to immediate cause. Find the arrivation (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U	t Di	AMENDED #23a, 2 23c. If yes 1 Live 4 Preg 9 Unk	a consequer 7, perMF, outcome of birth gnant at time nown	2, g868, pregnancy of death $\frac{2}{5}$	Fe Ot	tal death ther (Spec	3 [fy)			23e. l	Yes 2 Was an autopsy	Month co use cont No 3 24b.	Were a prior to death?	Day the cause of obably 4 utopsy finding completion of	death? Unknown s available
E - E	Completed by Physician/Medical	if any, leading to immediate cause. Finer Uncarrying Cause (Disease or injury that initiated events resulting in death). Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U. Part II. Other significant cond	d	AMENDED #23a, 2 23c. If yes 1 Live 4 Preg 9 Unk	a consequer 7, perMF, outcome of birth gnant at time nown	2, g868, pregnancy of death $\frac{2}{5}$	Fe Ot	etal death ther (Spec underlying	3 [fy) cause gi	ven in Pa	art I.	23e. l	Oid tobace Yes 2 Was an autopsy	Month co use cont No 3 24b.	tribute to	Day the cause of obably 4 utopsy finding completion of	death? Unknown s available cause of
a a	Be Completed by Physician/Medical	if any, leading to immediate cause. Finer Unantying Cause (Disease or injury that initiated events resulting in death). Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U Part II. Other significant condessessions.	d	AMENDED #23a, 2 23c. If yes 1 Live 4 Preg 9 Unk	a consequer 7, perMF, outcome of birth gnant at time nown	nce of): 2, g868, pregnancy of death 5	Fe Ot	etal death ther (Spec underlying	3 cause gi	ven in P <i>e</i>	ort I.	23e. 1 1 24a. 1	Yes 2 Was an autopsy performer yes 2	Month co use cont No 3 24b.	were a prior to death?	Day the cause of bobably 4 visual properties of the cause of the country of the country of the cause of the	death? Unknown s available cause of
E - E	To Be Completed by Physician/Medical	if any, leading to immediate cause. Finer Unarrying Cause (Disease or injury that initiated events resulting in death). Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U Part II. Other significant cond 25. Was case referred to mediexaminer? 1 Yes 2 No 27. Manner of Death	d	AMENDED 23c. If yes 1 Live 4 Prec 9 Unk contributing	a consequer 7, perME, outcome of birth mant at time nown to death but	nce of): 2, g868, pregnancy of death 5 not resulting	Fe Ot	etal death ther (Spec underlying	3 cause gi	of Death Other	(Check	23e. 1 24a. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Oid tobace Yes 2 Was an autopsy performer Yes 2 Res	Month co use cont No 3 24b.	were a prior to death?	Day the cause of bobably 4 visual properties of the cause of the country of the country of the cause of the	death? Unknown s available cause of
After this certificate has been signed by the attending physician if funeral director, page 2 should be detached for use as the burial.	To Be Completed by Physician/Medical	if any, leading to immediate cause. Find Unarrying Cause (Disease or injury that initiated events resulting in death). Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U Part II. Other significant condexaminer? 1 Yes 2 No 25. Was case referred to mediexaminer? 1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pe	d. d. Juknown ditions (AMENDED #2.30, 2 23c. If yes 1 Live 4 Pres 9 Unk contributing	a consequer 7, perME, outcome of birth gnant at time nown to death but Inpatient te of Injury th, Day, Year)	pregnancy of death 2 ER/O 28b.	g in the u	tal death ther (Spec underlying	3 Cause gi	of Death Other y at Workes 2	(Check Nursin	23e. 1 24a. 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Ves 2 Was an autopsy performer fes 2 Rescribe how	Month co use continuo a la la la la la la la la la la la la l	were a prior to death?	Day o the cause of obably 4 utopsy finding completion of /es 2 er: Scene	death? Unknown s available cause of
After this certificate has been signed by the attending physician if funeral director, page 2 should be detached for use as the burial.	To Be Completed by Physician/Medical	if any, leading to immediate curs. Find Unartying Cares (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U Part II. Other significant cond 25. Was case referred to mediexaminer? 1 Yes 2 No 27. Manner of Death 1 X Natural 5 Period Care Care Care Care Care Care Care Care	d	AMENDED 1 23c. If yes 1 Unk 20	a consequer 7, perME, outcome of birth mant at time nown to death but	pregnancy of death 2 ER/O 28b.	g in the u	tal death ther (Spec underlying	3 Cause gi	of Death Other y at Workes 2	(Check Nursin	23e. 1 24a. 1 24a. 1 2 24a. 2 28f. Loca 28f. Loca	Ves 2 Was an autopsy performer fes 2 Rescribe how	Month co use continuous and large state of the lar	were a prior to death?	Day the cause of bobably 4 visual properties of the cause of the country of the country of the cause of the	death? Unknown s available cause of
After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial	To Be Completed by Physician/Medical	if any, leading to immediate curs. Find Unartying Cares (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U Part II. Other significant cond 25. Was case referred to mediexaminer? 1 Yes 2 No 27. Manner of Death 1 X Natural 5 Period Cases (Condent Cases) 2 Accident Interpretation (Condent Cases) 3 Suicide 6 Condent Cases (Condent Cases)	d	AMENDED #23a, 2 23c. If yes 1 Live 4 Pres 9 Unk contributing 28a. Da' (Mor	a consequer 7, perME, outcome of birth grant at time nown to death but Inpatient te of Injury th, Day, Year)	pregnancy of death 2 ER/Ot 28b.	g in the cutpatient	tal death ther (Spec underlying t 3 Di lnjury 2	3 Cause gi 6.Place DA 6. Injur 1 Y	of Death Other y at Work es 2 uilding, et	(Check Nursin	23e. l 1 24a. 24a. 1 v 29 only one) ng Home 28d. Desco	Did tobace Yes 2 Was an autopsy poerformer Yes 2 Fig. 18 Rescribe how the state of	Month co use continuous 24b. 24b. idence 6 injury occu	were a prior to death? Other	Day o the cause of obably 4 outopsy finding completion of //es 2 er: Scene	death? Unknown s available cause of
After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial	Certification: To Be Completed by Physician/Medical	if any, leading to immediate cause. Financian Thanking Cause (Disease or injury that initiated events resulting in death). Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 UPART II. Other significant condexaminer? 1 Yes 2 No 9 UPART II. Other significant condexaminer? 1 Yes 2 No 9 UPART II. Other significant condexaminer? 1 Yes 2 No 9 UPART II. Other significant condexaminer? 1 Accident 1 Natural 5 Period Accident 1 Natural 5 UPART II. Other significant Cause III. Other significant Cause III. Other significant III. Other significant Cause III. Other significant Cause III. Other Significant Cause III. Other	d	23c. If yes 1 University 1 University 1 University 28a. Data (Morn 1 28a. Place (Specific at a Late to the late to	a consequer 7, perMF, outcome of birth gnant at time nown to death but Inpatient te of Injury 1th, Day, Year)	not resulting 2 ER/O 28b.	g in the cutpatient	tal death ther (Spec underlying 2 t 3 Di Injury 2 reet, factory,	3 Cause gi	of Death Other y at Work es 2 uilding, et	(Check Nursin:?) No tc.	23e. I 1 24a. 24a. 1 1 29 28d. Description on Total	Did tobace Yes 2 Was an autopsy performer Yes 2 Rescribe how	Month co use continuous 24b. 24b. 12 No idence 6 injury occu	were a prior to death? Other or R	Day o the cause of obably 4 visual representation of the cause of obably 4 visual representation of the cause of obably 4 visual representation of the cause of obably 4 visual representation of the cause of obably 4 visual representation of the cause of obably 4 visual representation of the cause of obably 4 visual representation of the cause of obably 4 visual representation of the cause of obably 4 visual representation of the cause of obably 4 visual representation of the cause of obably 4 visual representation of the cause of obably 4 visual representation of the cause of obably 4 visual representation of the cause of obably 4 visual representation of the cause of the	death? Unknown s available cause of
After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial	Certification: To Be Completed by Physician/Medical	if any, leading to immediate cause. Financian Interest In	d	23c. If yes 1 University 1 University 1 University 28a. Data (Morn 1 28a. Place (Specific at a Late to the late to	a consequer 7, perME, outcome of birth mant at time nown to death but Inpatient te of Injury th, Day, Year) ace of Injury iy) sest of my knus of examina	not resulting 2 ER/O 28b.	g in the cutpatient	tal death ther (Spec underlying 2 t 3 Delinjury 2 Injury 2 test, factory,	3 General Section of the section of	of Death Other y at Work es 2 uilding, et	(Check Nursin:?) No tc.	23e. I 1 24a. 24a. 1 1 29 28d. Description on Total	Did tobace Yes 2 Was an autopsy overformer of the second o	Month co use continued and service of the service	were a prior to death? 1 V Y Otherwise or Research	Day o the cause of obably 4 visual representation of the cause of obably 4 visual representation of the cause of obably 4 visual representation of the cause of obably 4 visual representation of the cause of obably 4 visual representation of the cause of obably 4 visual representation of the cause of obably 4 visual representation of the cause of obably 4 visual representation of the cause of obably 4 visual representation of the cause of obably 4 visual representation of the cause of obably 4 visual representation of the cause of obably 4 visual representation of the cause of obably 4 visual representation of the cause of obably 4 visual representation of the cause of the	death? Unknown s available cause of No
ours after death. eral Director: After this certificate has been signed by the attending physician i filled in by the funeral director, page 2 should be detached for use as the burial	To Be Completed by Physician/Medical	if any, leading to immediate cause. Find Unantying Cause (Disease or injury that initiated events resulting in death). Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U Part II. Other significant condexaminer? 1 Yes 2 No 27. Manner of Death 1 X Natural 5 Perecurrence of the condexaminer of Death 2 Accident In Suicide 6 Cd 4 Homicide 29a. Certifier 1 Certifying one) 2 Medical E 29b. Signature and title of certifier of certifie	d	28a. Plie (Specification of the basis and manner)	a consequer 7, perMF, outcome of birth gnant at time nown to death but Inpatient te of Injury 1th, Day, Year) ace of Injury 1y) sest of my known s of examinar stated.	not resulting 2 ER/O 28b.	g in the cutpatient	tal death ther (Spec underlying 2 t 3 Delinjury 2 Injury 2 test, factory,	3 General Section of the section of	of Death Other y at Work es 2 uilding, et death oc	(Check Nursin:?) No tc.	23e. I 1 24a. 24a. 1 1 29 28d. Description on Total	Did tobace Yes 2 Was an autopsy performer Yes 2 Rescribe how	Month co use continued and service of the service	were a prior to death? Other or R one as stated due to to the gened (Market)	Day of the cause of obably 4 vilutopsy finding completion of view 2 err: Scene Rural Route Number of the cause (s)	death? Unknown s available cause of No
After this certificate has been signed by the attending physician if funeral director, page 2 should be detached for use as the burial-	Certification: To Be Completed by Physician/Medical	if any, leading to immediate cause. Financian interest line flower than the constant of the constant in the constant in the constant in the constant interest line. The constant interest line is a constant in the constant interest line. The constant interest line is a constant interest line. The constant interest line is a constant interest line. The constant interest line is a constant line. The constant line is a constant line is a constant line. The constant line is a constant line is a constant line. The constant line is a constant line is a constant line is a constant line is a constant line. The constant line is a constant line	d	28a. Dai (Morini To the basiand manner	a consequer 7, perME, outcome of birth gnant at time nown to death but linpatient te of Injury with, Day, Year) ace of Injury iy) lest of my knus of examinar stated.	pregnancy of death 2 of death 2 not resulting 2 ER/O 28b At home, fa	g in the cutpatient	tal death ther (Spec underlying 2 t 3 Delinjury 2 Injury 2 test, factory,	3 6.Place of 6.Place o	of Death Other y at Work es 2 uilding, et death oc	(Check Nursin:?) No tc.	23e. I 1 24a. 24a. 1 1 29 28d. Description on Total	Did tobace Yes 2 Was an autopsy performer Yes 2 Rescribe how	Month co use continuous 24b. 24b. 22b. injury occu et and Num place, and	were a prior to death? Other or R one as stated due to to the gened (Market)	Day of the cause of obably 4 vilutopsy finding completion of view 2 err: Scene Rural Route Number of the cause (s)	death? Unknown s available cause of No
After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial	Certification: To Be Completed by Physician/Medical	if any, leading to immediate cause. Find Unarrying Cause (Disease or injury that initiated events resulting in death). Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U Part II. Other significant condexaminer? 1 Yes 2 No 27. Manner of Death 1 X Natural 5 Period Accident Into 3 Suicide 6 Condexaminer 1 Certifying One) 2 Medical E 29b. Signature and title of certifier (Check only One) 2 Medical E 29b. Signature and title of certifier 30. Name and address of pers	d	28a. Dai (Mornin To the basiand manner completed care)	a consequer 7, perME, outcome of birth gnant at time nown to death but linpatient te of Injury with, Day, Year) ace of Injury iy) lest of my knus of examinar stated.	pregnancy of death 2 of death 5 not resulting 2 ER/Or 28b. At home, fa	utpatient Time of I arm, stre	tal death ther (Spec underlying 2 t 3 Delinjury 2 Injury 2 test, factory,	6.Place of time, da opinion, License O.C.N	of Death Other y at Work es 2 Juilding, et death oce e number	(Check Nursing Record and American Record and American Record and American Record and American Record and American Record and American Record and American Record and American Record and American Record and American Record	23e. 1 24a. 1 24a. 1 25 28f. Loca or To d due to the at the time,	Did tobace Yes 2 Was an autopsy performer Yes 2 Rescribe how	Month co use continuous 24b. 24b. 22b. injury occu et and Num place, and	were a prior to death? Other or R one as stated due to to the gened (Market)	Day of the cause of obably 4 vilutopsy finding completion of view 2 err: Scene Rural Route Number of the cause (s)	death? Unknown s available cause of No
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician is completely filled in by the funeral director, page 2 should be detached for use as the burial.	Certification: To Be Completed by Physician/Medical	if any, leading to immediate curs. Find Unartyin Cares (Disease or injury that initiated events resulting in death) Last X UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U Part II. Other significant cond 25. Was case referred to mediexaminer? 1 Yes 2 No 27. Manner of Death 1 X Natural 5 Perecurs of the condition of the co	d	AMBINDED 23c. If yes 1 Live 4 Prec 9 Unk contributing 28a. Da (Mor ne e (Specification) 1 Completed cassistant	a consequer 7, perMF, outcome of birth gnant at time nown to death but linpatient te of Injury hith, Day, Year) ace of Injury hith, Day, Year) ace of fingury hith, Day, Year) ace of fingury hith, Day, Year) ace of fingury hith, Day, Year) according to the control of the	pregnancy of death 2 ER/O 28b At home, fa owledge, death of (Item 23a) Examiner	utpatient Time of I arm, stre	tal death ther (Spec underlying 2 t 3 Di linjury 2 pet, factory, unred at the stion, in my	6.Place of time, da opinion, License O.C.N	of Death Other y at Work es 2 Juilding, et death oce e number	(Check Nursing Record and American Record and American Record and American Record and American Record and American Record and American Record and American Record and American Record and American Record and American Record	23e. 1 24a. 1 24a. 1 25 28f. Loca or To d due to the at the time,	Did tobace Yes 2 Was an autopsy performer Yes 2 Rescribe how	Month co use continuous 24b. 24b. 22b. injury occu et and Num place, and	were a prior to death? Other or R one as stated due to to the gened (Market)	Day of the cause of obably 4 vilutopsy finding completion of view 2 err: Scene Rural Route Number of the cause (s)	death? Unknown s available cause of No

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene' State
Registra AMEND#23a/boerMD 6/6/07, BMW, MoCo Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 28, **Physician** 2007 May 1:49 P. M Irving M. Hecht /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 01ney Montgomery General Hospital 8. Date of Birth (Month, Day, Ye July 19, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Year) New York Months Days Hours Min 1₩ 2□F 1915 113-05-4153 91 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 1√PYes 2 No Director Silver Spring Maryland| Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3280 Brookside Court 20906 U. S. A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 X Yes 2 □ NAirforce
If Yes, Give
Year or Dates: WW 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify Specify: Completed by White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) T.aw Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sophie (Unknown) Isadore Hecht ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2090619a. Informant's Name/Relationship (Type. Print) 3346 Chiswick Court, # 2-B, Silver Spring, Md. Francine E. Flynn - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/30/2007 Adelphi, Maryland <u> Mount Lebanon</u> 21. Signature of Funeral Service Licensee Banzansky Cofatberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the doubth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Aspiration Onset and Death Immediate Cause (Final disease or condition resulting in death) pneumonia **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last PPITETION Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of). the attending physician the for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 2 No 2 100 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpatient 3 DOA 2 No Medical Certification: To this the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide e Funeral 1 🗸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

D

18101 Prince Philos Drue, Olney

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32 Registrar's Signature

Robert Kirkelldy, MO

06

31. Date filed (Month, Day, Year)

JUN

D0061681

05/29/2007

Robert Bennett F		State of Maryland / Department of Health and Mental H 1-For State Certificate of Death	lygiene	E-ma	97 1990		
Physicia Medical Examii	ın/	1. Decedent's Name (First, Middle,Last)	Reg. 2. Date of Death Month D		3. Time of Death		
Medical Examin	lei	Robert Bennett Hill 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deating Hyattsville	Month D June 3, 2007	4c. County of De Prince Geor	ath		
Funeral Director	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr. Months Days Hours Mir		MM/DD/YYYY) 9. I	Birthplace (State or eignWashington Country) DC		
aryland 8a-f show any at once.	or	Usual Residence of Decedent 10a. State			10d. Inside City Limits 1 X Yes 2 No		
th the Maryland 23a or 28a-f sho notified at once.	Il Director	10e. Street and Number 10f. Zip Code 4808 Stockton Lane 20781		Citizen of What Co			
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Heatth and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f she r traumatic event, the Medic Examiner must be notified at once.	y Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 X Divorced If Yes, Give Year 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Solit Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Am White, etc Specify: Wh			
36 in 72 hours a han "natura die 4 Examin	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret	ired)	6b. Kind of Busines	s/Industry		
21215-0036 suld be filed within 72 Mental Hygiene. marked other than c event, the Medic 4	Be Com	12 Property Manage 17. Father's Name (First, Middle, Last) Edwin William Hill Edna Ma	e (First, Middle, Mai		Estate		
MD 21 and 2 should I afth and Mer m 27 is mar aumatic eve	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Debra Cromwell - Daughter 2236 Lesner Cres #	100, Virg	inia Bea	ch, VA 23451		
imor Pages ment of tant: If		4 Uphation 5 Other Specify:	9/2007	20c. Location - City or Town, State Brentwood, Maryland			
Balt Balt Departing Importing		21. Significantly funded by the state of Funders of Funders of Funders of Funders of Funders of Funders of Funders of Funders Funders Howard Funders of Funders Howard Funders of Funders Howard Funders of Funders Howard Funders of Funders Howard Funders of Funders Howard Funders of Funders Howard Funders of Funders Howard Funders of Funders Howard Funders of Funders Howard Funders Funders Howard Funders Funders Howard Funders Funders Howard Funders Funders Howard Funders Funders Funders Howard Funders Fund	meP.A. Hya		Approximate Interval		
/Medical xaminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherbsclerbtic Cardiovascular Disease Due to (or as a consequence of):			Between Onset and Death		
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated			- 12-17		
execut an and al - tra	dical Exa	events resulting in death) Last Due to (or as a consequence of): d. UNPENDED AMENDED		······································			
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be reath. retor: After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the buri	ŝ	15 FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)	ancy	23d. Date of deliv Month	ery Day Year		
, P.O. Box ires that the death c signed by the atten		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus; dementia			to the cause of death?		
of Vital Records, F 19 Physician: The law requires ther this certificate has been sign meral director, page 2 should be	Completed by	Diabetes meinus, demenia	24a. Was an autopsy performe	24b. Were prior t	autopsy findings available o completion of cause of ?		
Vital Reco ysician: The law his certificate has director, page 2 si	Bec	25. Was case referred to medical examiner?			Tes 2 NO		
of Viling Physic	유	1 V Yes 2 No Inspiral 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursin		sidence 6 V Oth	ner: Scene		
Division of 'pital or Attending Phours after death. Iteral Director: After tilled in by the funeral	Certification:	1 V Natural 5 Pending Investigation Investigation 28e Place of Injury - At home, farm, street, factory, office hullding, etc.	No .				
E 6 6 5	- 1	3 Suicide 4 Homicide Could not be determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	or Town, State	e)			
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier 29c. License number	at the time, date and		the cause(s)		
Fia)	Fatur Coronica - Pollah us 30. Name and address of person who completed cause of death (Item 23a)	J	June 4, 2007			
SCIA		Patricia Arpnica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimor	re, MD 21201				
Ste	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature					

DHMH 17 Rev 1/2001 OCME 2006

Registrar JUN 0 8 2007

ORIGINAL

OCME

			1 - For State Registrar	tate of Maryla		artment of I rtificate of		nd Mei		giene Reg. No. 2	07	1590
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Helen C. Herres						Date of Dea Month Lay 29	Day	Year	3. Time of Death 8:15 A. M
	Exami		4a. Facility Name (If not institution, give stree Sacred Heart Nursing	ŕ		4b. City, Town, o				4c. Count		
	Funeral Director		5. Social Security Number 6. Sex 119–30–6701	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Min. A	Date of Birtl (Month, Day ug.21,	1918	I Cot	nplace (State or Foreigr untry) EXAS
	faryland show ed at	'n	Usual Residence of Decedent 10a. State 10b. County		ity, Town or Lo							10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the Na or 28a-f	Director	MD P.G. 10e. Street and Number	Mt.	RAini	10f. Zip Code				10g. Citizen of		
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	1 Never Married 2 Married 1	Vas Decedent Ever in l Armed Forces? ☐ Yes 2 M No f Yes, Give fear or Dates:		207] Was Decedent of H If Yes, specify Cub 1 □ Yes 2⊠ No		n? (Specify Puerto Ric	/ Yes or No- an, etc.)	U.S.A. 14. Radisla Special	ce - Amer ck, White	
1215-0036	within 72 hou ene. than "natura" he Medical Ex	Completed I	15. Decedent's Educatio (Specify only highest grade cor	n	(Give life. I	dent's Usual Occup kind of work done DO NOT use retire al Worke:	during most o	of working		16b. Kind of B	usiness/l	
Maryland 21	m = 0 W	To Be Co	17. Father's Name (First, Middle, Last) Balie T. Cantrell	51	3001	ar worker	18. Mother's		irst, Middle, e Kone	Maiden Surna		
	s 1 and 2 should be if Health and Ments item 27 is marked other traumatic ev		19a. Informant's Name/Relationship (Type. F Abigail H. Herres/Da			ng Address <i>(Street</i> 29th St.					, State, Z	ip Code)
altimore,			20a. Method of Disposition 1 ☐ Burial 2 【3 Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	vai iroini State		sition (Name of natory or other pla	1/2	Date /	- ~	20c. Location Brentwo	,	,
Ball	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service Licensee	Coffeler	3	2. Name and Addre	ensburg	g Rd.	, Bren	ln F. I		20722
	Physician /Medical		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call Immediate Cause (Final disease or condition resulting in death)	ons that caused the dea use of each line. Alzheimer 's Due to (or as a conse	s disea		ng, such as ca	ardiac or re	espiratory arr	rest,		Approximate Interval Between Onset and Death Unknown
08/00,	ireate be executed physician and physician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last d	Due to (or as a consecutive to (or a))).	quence of):							
O. Box oc	requires that the death certifice een signed by the attending ph nould be detached for use as th	Physician/Med	in the past 12 months?	yes, outcome pf pregn □Live birth 2 □ Fet □ Pregnant at time of □ Unknown	al death 3□	Ectopic pregnanc	у				ite of deliventh	very Day Year
ecords, P	w requires that been signed b should be deta	ğ	Part II. Other significant conditions contributions Dementia, hypertens				en in Part i.					the cause of death?
	The law ate has b page 2 sl	Completed					h=-058 3	-	24a. Was a autops perfor 1∐ Yes	med?	prior to co death?	topsy findings available completion of cause of
ा शास्त्रा	hysiciar this certif al director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospi	T ☐ Inpatient Z ☐] ER/Outpatien		er: 4 🔼 Nursi		heck only on 5 ☐ Reside	<i>e)</i> ence 6 □Oth	ner (Spec	ify)
VISIOI	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	Ba. Date of Injury (Month, Day Year) Be. Place of Injury - At h	28b. Time of Injury	M 1	ryat rk? Yes 2∐No	,		ow injury occur		ral Route Number.
2	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /		4 Homicide	building, etc. (Speci	fy) wledge, death	occurred at the ti	me, date and	place, and	City or Town	n, State) ause(s) and m	anner as	stated.
	o the Ho ithin 24 h o the Fu ompletely	Medical	(Check only 2 Medical Examiner:	On the basis of examinand manner stated.	ation and/or inv	vestigation, in my o	opinion, death	occurred a	at the time, o	late and place,	and due	to the cause(s)
^	F 3 F 8		· Chow dly, n			D43				June 6	•	
1.	L/2		30. Name and address of person who comple Nurul Chowdhury, M	m; 15216 D	ino Dr.		sville	, MD	20866			
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrar's Sign	Aire							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year :38P.M JUNE 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard County Columbia

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 😿 F Yrs. 579-10-8816 92 Director May 10, 1915 Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1x Yes 2 No Director DC N/A Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with "natural", or items 23a 1501 Neal St., N.E 20002 U.S. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No if Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Black 3 Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Statistician Fed. Gov't. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Charles Henry Franklin Merdis White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any Injury or other trae Franklin / Alonzo Edward Son 5465 Luckpenny Place, Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 8, 2007Suitland, MD Lincoln Memorial 21. Signature of Fineral Service License 22. Name and Address of Facility McGuire Funeral Service, Inc. re 7400 Georgia Ave., N.W. Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 30 Minutes /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and sthe burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9☐Unknown signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has bage 2 s autopsy performed? Yes 2 No 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 Yes 2 No P this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural ours after death.

neral Director: Af
filled in by the fu 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JUNE 03,200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AB 10820 HICKOTY Kida 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 05 2007 Registrar

			1 = For State Registrar		artment of Health and rtificate of Death	, ,	ene	
	Physic /Medi		Decedent's Name (First, Middle, Last) CHARLES	HODGE		2. Date of Death	1 2	3. Time of Death 0157 M
م	Exami		4a. Facility Name (If not institution, give street a Shady Grove Adve) 5. Social Security Number 6. Sex			9	4c. County of Death MONTGOM	
	Funeral Director		251-48-5400 1X M 2 Usual Residence of Decedent		Months Days Hours Mi		rear) Count	lace (State or Foreign try) Carolin
	e Maryland a-f show lifled at	ctor	10a. State 10b. County MOntgome:	10c. City, Town or L	aithersburg		10	0d. Inside City Limits 1 XYes 2 No
	th with the 23a or 28 ust be not	ral Director	10e. Street and Number 9 Chestnut St	reet, #119	10f. Zip Code 20877	100	g. Citizen of What Count U.S.A.	try?
5-0036	ours after dez ral", or items Examiner m	by Funeral	1 ☐ Never Married 2 Married 1 ☐ If Y	s Decedent Ever in U.S. ned Forces? 13. 17. 17. 17. 18. 19. 19. 19. 19. 19. 19. 19. 19	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 ☑ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - America Black, White, e	
21215-0	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) 3rd Col	leted) (Give life.	dent's Usual Occupation kind of work done during most of w DO NOT use retired) Free Cutter	vorking 16	Sb. Kind of Business/Ind	•
Maryland 2121	ould be filed Mental Hyg larked othe	To Be C	17. Father's Name (<i>First, Middle, Last)</i> Ken Hodge			ame (First, Middle, Ma Leila Ge	rald	
e, Mar	1 and 2 sh Health and em 27 is m		19a. Informant's Name/Relationship (Type. Pri. Maeola Hodge (Wii 20a. Method of Disposition	,	ng Address (Street and Number or nestnut St, #1	.19, Gait		MD 2087
Baltimore,	t. Page rtment c rtant: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Ophation 5 ☐ Other (Specify) 21. Signature of Funeral Service → Copplee	from State Riverda	matory or other place) ale Park Cre 6 2. Name and Address of Facility S	5/3/07 R	iverdale,	MD
Ba	permi Depa Impo any ir		23a. Part1. Enter the disease, or complications	that caused the death, o not en	46 N. Washingt	on St, Ro	ckville,M	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	e on each line. Diabetes ue to (or as a consequence of):				Interval Between Onset and Death Years
8760,	ficate be executed physician and physician stransit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Respiratory ue to (or as a consequence of): ue to (or as a consequence of):	Failure	_	1	minutes
P.O. Box 68	eath certif attending for use a	Physician/Med	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery	y Day Year
	w requires that the d been signed by the should be detached	ed by Pr	Part II. Other significant conditions contributin	g to death but not resulting in the u	nderlying cause given in Part I.		cco use contribute to the	~ /
Vital Records,	in: The law re dificate has been or, page 2 sho	Completed by	25. Was case referred to medical				prior to com death?	sy findings available pletion of cause of 2□ No
Division or Vi	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	To B	examiner? 1	1 ☐ Inpatient Date of Injury (Month, Day Year)	t 3 DOA Other: 4 Nursing	Home 5 Residence 28d. Describe how	ee 6 □Other (Specify) injury occurred	
Divis	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Certification:	4 Homicide determined	Place of injury - At home, farm, str building, etc. (Specify)		City or Town, S		
	thin 24 ho thin 24 ho the Fune	Medical	Check only 2 Medical Examiner: On	To the best of my knowledge, deat the basis of examination and/or in manner stated.	n occurred at the time, date and pla vestigation, in my opinion, death oc 29c. License number	curred at the time, date	e and place, and due to t	the cause(s)
	F B F 8		· PBal		D6332	, &	5-31-0°	*
	Sta		30. Name and address of person who completed Poopaj Bakhtiari B1. Date filed <i>(Month, Day, Year)</i>		edical Center	Dr, Rock	ville,MD	20850
	Registr		JUN 0 5 2007	House It April	de la company de			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 🦾 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day **Physician** Havis Eleanor Collier May 5:20 p M 31, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner College Park 6812 Dartmouth Avenue Prince George's 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 X F 281-10-2791 Director 96 May 5, 1911 Ohio Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits 'natural', or items 23a or 28a-f show dical Examiner must be notified at 1 X Yes 2 No Director Maryland Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6812 Dartwouth Avenue 20740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2K No Specify: White þ 3 X Widowed 4 □ Divorced Completed the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) University of Maryland Elementary/Secondary (0-12) College (1-4or 5+) Clerk Book Exchange 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Collier Blanche Pearce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al important: If item 27 is any injury or other trau Kathy H. Fuller - Daughter 59th Place, Hyattsville, Maryland 20781 Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 06/11/2007 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. 2. Part1. Enter the disease, one implications that caused the shock, or heart failure. List only one cause on each line Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Approximate Interval Between Onset and Death mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician Acute Aspiration 3 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the bunal-tran Due to (or as a consequence of) Physician/Medical IE EEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 5 ☐ Other (specify) ed by the a 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Syndrome 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No ate has page 2 s autopsy 2 0 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 28b. Time of 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 Yes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical All Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6-4-2007

State Registrar

Saltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

6492 Landover Rd, Landover.

00012015

30. Name and address of person who completed cause of clath (Item 23a) (Type, Print)

32. Registrar's Signature

Steinberg, M.D.

31. Date filed (Month, Day, Year) JUN 0 7 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITM#20b partiff, \$68,6/20/07 WS.
State of Maryland 7 Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** MARSHALL T. HEAPS Month Year JTR. /Medical 2007 June 11:51 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1860 Whiteford Road Street Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State Months Days Hours Min. | March 26, 1930 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 15√m 2□ F 219-36-2454 77 Yrs. Director Usual Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shot other traumetic event, it a Musical Examinat must be notified at Funeral Director MD Harford 1 ☐ Yes 2 🛣 No Street 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1860 Whiteford Road 21154 USA 12. Was Decedent Ever in U.S. Armed Forces? PONes 2 □ No If Yes, Give Year or Dates: 1951–53 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No Be Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Item 27 ie marked other than Elementary/Secondary (0-12) Oil & Gas Coltege (1-4or 5+) Owner/Operator Distribution 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marshall Thomas Heaps Sr. Helen Wells Arthur 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Retationship (Type, Print) Ann A. Heaps- wife 1860 Whiteford Rd., Street, MD 21154 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If eny injury or once. injury or Slate Ridge Cemetery 6/19/07 Delta, PA 17314 21. Sign Jure 1 Funeral Service Licensee 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 23a Part 1. Enter the disease, or complications that caused the bath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Tardiopul monary /Medical Due to (or as a consequence of): Examiner 5 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit attending physician and Due to (or as a consequence of) Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1X Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1□ Yes 25. Was case referred to medical Be 26. Place of Death Check only one examiner 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home this 5 Residence 6 □Other (Specify) After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. Director: A investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled it Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) the 29b. Signature and title of certifie, 29d. Date signed (Month, Day, Year) 29c. License number 6/12/2007 1) 0063981 MD. 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Benjamh Cee, MD 669 Revolution St. Havre de Grap, MD 20078 9

State Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760.

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 5/28/2007 Maxine Grubbs Hamersley 8:54 and /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Shadyside 4937 Hine Dr. Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Date of Birth (Month, Day, Year) 1/17/1919 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1 □ M XXX F Virginia 223-26-5933 88 **Director** Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "naturel", or Items 23e or 28e-f show the Medical Erantiner must be notified at 1 ☐ Yes 🎗 🛱 No by Funeral Director MD Anne Arundel Shadyside 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4937 Hine Dr. 20764 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 23€ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturer, or item any injury or other treumatic event, the Mental State." 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: White 3₺Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Robert S. Grubbs Sr. Reno Clyde Grant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rebecca Lowe Daughter 4937 Hine Dr. Shadyside, MD 20764 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Prospect Hill Cemetery 6/1/2007 XXBurial 2 ☐ Cremation 3 ☐ Removal from State Front Royal, VA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilityHardesty Funeral Home, P.A. 21. Signature of Funeral Service License Date 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANCINOMA Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of) Box 68760 attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Year Po in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. the detached 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has 2 **2 N**e 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifics 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 2 funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier death (Item 23a) (Type, Print) 30. Name and address of person who completed cau 6131 Shady Side JUN 0 4 2007 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Vaar 07 07 0907 HAENFTLING 06 EARL FREDERICK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **BRADDOCK CAMPUS** ALLEGANY WMHS CUMBERLAND 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 9, 9. Birthplace (State or Foreign 5. Social Security Numbe **Funeral** Days Hours 1**X** M 2□ F 1920 Maryland 86 June Director 220-10-0946 Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f shov ral", or items 23a or 28a-f sh Examiner must be notified 1 X Yes 2 No Directo Accident Garrett 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 215 S. Main St., P.O. Box 45 21520 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: \ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced WW2 "natural" Completed er than "natur the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene U.S. Postal Service 12 Postmaster 27 Is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Prema Schlossnagel Walter Henry Haenftling ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health 215 S. Main St., P.O. Box 45, Accident, MD 21520 27 Mildred V. Haenftling/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Cemetery June 10, 2007 Accident, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun ral Service Libensee 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** WITH MEDICAL CUZE AT disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner D Sequentially list conditions, if any, leading to initional cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician a the burial Division or Vital Records, P.O. Box 68760, Physician/Medical 8,2007 DUNE aftending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Was ... autopsy performed cate has to certificate 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 2 *No 2∐ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending Investigation Injury 1 Natural A)20 01 in 24 hours after death.

Reference Director; A pletely filled in by the fu 1 ☐ Yes 2 17 No 2240 ATLENT 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 28f. determined 4 Homicide MOTEL GRAMS VICLEM 21531 NURSING Hop & DORSei/ Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune
completely fi Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland / Department of Health and Certificate of Death		giene	
			1. Decedent's Name (First, Middle, Last)	2. Date of Dea	ath Day Year	3. Time of Death
	Physici /Medic Examin	al	RICHARD EUGENE HOFFMAN SR. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	JUNE	6 2007 4c. County of Dea	1:32 A M
	Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	s. 8. Date of Birt	WASHT b, Year) 9. Bir C. 1947 M.	NGTON thplace (State or Foreign punity) ARYLAND
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	he Mary	Director	MARYLAND WASHINGTON BOONSBORG			1 ☐ Yes 2 🙀 No
	a or 2	Dir	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	·
	eath	eral	8434 MOUNTAIN LAUREL ROAD 21713 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	U.S	
36	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f ehow the Medical Evarities from the recitied at	by Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No If Yes, Sieve 1 □ Yes 2 ☑ No Specify: 1 □ Yes 2 ☑ No Specify:	rto Rican, etc.)	Specify:	
5-0036	2 hou		15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business	
212	thin 7.	pie	(Specify only highest grade completed) (Give kind of work done during most of work done during m	orking		
7	filed within I Hygiene. other than	Completed	12 PAVER OPERATOR		PAVING CO	OMPANY
Maryland	d a b	Be		ame (First, Middle,	,	
3	should the marker imatic	T ₀			E KEPHART	
<u>8</u>	od 2 st lith and 27 Is r r traur		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F			
Baltimore,	Tage Head		TERESA M. HOFFMAN/SPOUSE 20a. Method of Disposition 1 🛮 Burial 2 □ Cremation 3 □ Removal from State	Date	20c. Location - City or	
	it. Pa rtmen rtant: njury			9/2007	BOONSBORO,	
g	permit. Pages Department of I Important: If its any injury or o'		21. Signature of funeral Service Ucensee Paul M. Dean BAST FUNERAL HOME		d National	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	BOONSDO ac or respiratory ar	ro, Marylaı rest,	Approximate
	Pnysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a			Interval Between Onset and Death 2 Years
	/Medical Examiner		Due to (or as a consequence of):			
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
Ď,	ate be executed hysician and the burial-transit	i Exan	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
26/60	icate b physic s the b	dicai	d			
O. BOX 6	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown		23d. Date of de Month	livery Day Year
S, F.	requires that the de een signed by the a nould be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to	the cause of death?
cords,	w requir been si should	etec		-		
Ţ	The far ate has page 2	Completed		24a. Was autop perfor 1 Yes	sy prior to death?	utopsy findings available completion of cause of
VITal	sician: Th certificate irector, pag	Be	eyaminer'/	eath (Check only or		
0	Phys this al dir	J.	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		ence 6 Other (Spe	cify)
DIVISION	ding h. After fune	ertification;	1 ☐Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No	28d. Describe n	ow injury occurred	
2	Dir	Certific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	itreet and Number or Ri m, State)	ural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and the place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and the place 2 Medical Examiner: On the basis of examination and/or investigation.	e, and due to the c curred at the time, o	ause(s) and manner as date and place, and due	stated. to the cause(s)
	To tha within 2 To tha complet	Me	29b. Signature and title of certifier 29c. License number	ł .	29d. Date signed (Mont	
			Muchael J. Machemet MD D41667		6.6.0	~
كا	H-10		Muchael J. Muchael MD D4 1667 30. Name and address of person completed cause of death (Item 23a) (Type, Print) Michael McCornect IIII Medical Campa 31. Data filled (Month Pay Year) 32. Registrar's Signature	1 Her	erstun	MO.
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	riegioti		JUNIO C 2007 Market John Johnson			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 23:48 2007 Betty Jean Hart /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington Washington County Hospital Hagerstown Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Min. Hours 1 □ M 2 🔀 F 76 04/14/1931 151-22-3672 NYDirector Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be martified. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County MD Washington Hagerstown 1 X Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 US 11 W. Baltimore Street, #609 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give 1 ☐ Never Married 2 ☐ Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Associate Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Virginia Williams Theodore Roosevelt Cheatam ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11 Temons Court, Baltimore, MD 21244 19a. Informant's Name/Relationship (Type. Print) Denise Durham / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 06/11/2007 Cedar Lawn Mem Gdn Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral 21. Signature of Funeral Strvice Licansee 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final o months Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 has certificate 1□ Yes 2 No Physician: 25. Was case referred to medical examiner? director, 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 DER/Outpatient 3 DOA 1 🔲 Inpatient 1 ☐ Yes Certification: To after death.

I Director: After this of in by the funeral di 27. Manner of Death 1 Natural 28a Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide n 24 hours aft le Funeral Di letely filled in 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely

3H-6

the

2

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11110

29c. License number

29d. Date signed (Month, Day, Year)

Medical Campus Rd Hagerstown Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 5 Day 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2007 **Physician** 8:04 A M June Donato A. Iacobazzi /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Glen Burnie Baltimore Washington Medical Ctr. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 19,1951 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 12XM 2□F Italy 55 529-80-3205 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If liem 21 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 → No Director Anne Arundel Odenton MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21113 USA 608 Crawford Ridge Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No 5-0036 Specify: White <u>\$</u> 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2121 Elementary/Secondary (0-12) College (1-4or 5+) Insurance Underwriter 4 18. Mother's Name (First, Middle, Maiden Surname) and 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Michaela Iacobazzi Francesca Detoma 2 Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21113 608 Crawford Ridge Rd. Odenton, MD. Patricia Iacobazzi / spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 Burial 2 □ Cremation 3 □ Removal from State Lakemont Mem. Gardens 06/08/2007 Davidsonville, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licènsee Beall Funeral Home 20715 6512 NW Crain Hwy. Bowie, MD. Toc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) months **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical attending p 23c, If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 1 ☐Live birth 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) o ed by the a 9□Unknown 9 Unknown ٦. 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate 1□ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 FR/Outpatient 3 DOA 1 ☐ Yes 2 No 1 🔲 Inpatient P this 27. Manner of Death 1 Natural funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? After Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After (Month, Day Year) 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Markay M.D D39505 June 6,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yodhish Markon 305 Hospital Dv. Glen Burnie, 32. Registrar's Signatu 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Q

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	Marylan		artment o			lental Hyg	giene lag. Ńo.	107	13914
	Physici	an	Decedent's Name (First, Middle							2. Date of Dea Month	Day	Year	3. Time of Death
136	/Medio	cal	Johnnie Jones 4a. Facility Name (If not institution,		thar)		4h Cily Tow	n, or Location	of Death	June		2007 ounty of Death	11:54 P.M
	Examin	ıer	Washington Adv	-				coma Pa				ntgomer	v
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye			8. Date of Birth			place (State or Foreign ntry)
	Director		247-30-4960	1 ⊠ M 2□F	80	Yrs.	WOT(ITS Da	lys Hours	IVIII I.	8. Date of Birth (Month, Day 7/15/26	5	Greer	ville,S.C.
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Mary I sh	to	D.C.			Washin	gton						1 ☐ Yes 2 🙀 No
	or 28s	lrec	10e. Street and Number				10f. Zip Coo			1	_	n of What Cou	ntry?
	ath wi	ral	5817 Dix St.,					200				.S.A.	
98	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Iteme 23e or 28e-f show any Injury or other traumatic event, I'm Mudical Exert that must be incitied at an ance.	y Funeral Director	11. Marital Status 1 ☐ Never Married 2∑ Marri	ed 1X1Yes If Yes, Giv	^{2□} N°46-'	47	Was Decedent If Yes, specify (1 ☐ Yes 2 ∑			ecify Yes or No- Rican, etc.)		. Race - Ameri Black, White pecify: B]	
21215-0036	hours turel'	ed by	3 ☐ Widowed 4 ☐ Divorced		ites:		dent's Usual Oc	cupation			16h Kind	of Business/Ir	
15	nin 72 n "na Medic	Completed	(Specify only highes Elementary/Secondary (0-12)		-40r 5+)	(Give	kind of work do DO NOT use re	one during mo:	st of workii	ng	700.71114		,
21	or tha	E O	12th	College (1	401 017	Cus	todial	Superv	isor		U.S	. Gover	nment
Maryland	be file	Be	17. Father's Name (First, Middle, I	Last)					er's Name y Ga]	(<i>First, Middl</i> e, .	Maiden Si	umame)	
2	thould nd Mer mark matic	J.	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	na Address (Str		-	I Route Number	r. City or 7	Гоwп. State. Zi	p Code)
S	nd 2 s tith an 27 is r trau	i i	Sara Jones/Wife				-			nington,			
ore,	of Hear Item		20a. Method of Disposition	2	20b. P	lace of Dispo	sition (Name o natory or other	f place)	D	Date	20c. Loca	ition - City or T	own, State
Ĕ	Page ment ant: If ury or		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		ו שוט		Nat'l.	1	6/12	2/07	Tria	angle,	Virginia
Baltimore,	permit. Departi Import any Inj phoe		21. Signature of Funeral Service I	Licensee O	all	22	Name and Add Add Add Add Add Add Add Add Add A	dress of Facil shingto irrough	n & S s Ave	ons Co	Wash	,D.C.	20019
	e (23a. Part1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	aused the deatl	h. Do not ent	er the mode of	dying, such as	s cardiac o	or respiratory arr	rest,		Approximate Interval Between
16.50	Physician		Immediate Cause (Final disease or condition resulting in death)	a	50	05%	2						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of): /							
a ⁿ	***	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a conseq	uence of):							
	outed id ansit	Examiner	that initiated events	с									
Ő,	e exer ien ar urial-t	Ex	resulting in death) Last		or as a conseq	uence of):							
8760,	icate be executed physicien and s the burial-transit	dlca		d									
9 X	certifii oding p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna	incy				*	23	d. Date of deliv	rerv
Box	death e atter d for u	clar	in the past 12 months?	4□Pregn	irth 2 ☐ Feta ant at time of d		Ectopic pregna Other (s <i>pecif</i>)					Month	Day Year
P.O.	at the by the	hys	9 🗆 Unknown	9□ Unkno									
	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	þ	Part II. Other significant condition	ns contributing to de	eath but not res	ulting in the u	nderlying cause	given in Part	1.		bacco use 'es 2 🗆		the cause of death? bably 4 Dunknown
eco	ne law re has bee ge 2 sho	Completed								24a. Was a		24b. Were aut	opsy findings available ompletion of cause of
五 田 田		Con								perfor 1 Tyes	med? 2 No	death?	2 No
Vita	Physician: rthis certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	/			Othor		(Check only or			
ō	Phys or this aral di	To It	1 Yes 2 No 27. Manper of Death	28a. Date	of Injury	ER/Outpatier 28b. Time o		4∐N Injury at Work?		me 5 Resid			ify)
ion	Attending r death. ector: After by the fune	atlor	1.☑Natural 5 ☐ Pending 2 ☐ Accident investig	9	h, Day Year)	Injury		Work? 1 ☐ Yes 2 ☐]No				
Division of Vital Records,	after de after de Directo	Certification:	3 Suicide 6 Could r 4 Homicide determ	ined 289. Place	of Injury - At hong, etc. (Specif		eet, factory, off	ice		28f. Location (S City or Tow	Street and in, State)	Number or Rui	al Route Number,
	To the Mospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifyin 2 Medical	g Physician: To the Examiner: On the ba and mann	best of my kno asis of examina ner stated.	wledge, deat tion and/or in	h occurred at the vestigation, in r	ne time, date a my opinion, de	nd place, a ath occurr	and due to the c ed at the time, c	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	000.	٨ ٨	10	29c. Lic	cerse number	112	121	29d. Date	signed (Month	Day, Year)
\cap	110		10.	U	411	P		1)	1)	TII		6/7	107
1	Va		30. Name and address of person	5/1	Veg	US	SIE.	1700	2.	Wasi	hi Si	1000	Adv. Hrs
	Sta Regist		JUN 0 7 2007	Berew 32. R	egistrar's Signa	ture							70

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician <u>5:30</u>p ^M Catherine Jackson 4 2007 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 177-20-2940 81 8/2/1925 Director Philadelphia, PA Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County 28a-f show 1 Nes 2 No notified Director Maryland Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral", or items 23a or Examiner must be r 16010 Excalibur Road, #A-308 20716 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Yes 2 XNo If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2X No þ Specify. 3 Widowed 4 Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ul Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Certified Nurse Aide Medica1 Pages 1 and 2 should be filed nent of Health and Mental Hygi is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Forrest Cureton Florence Marshall 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1537 West Loudon Street Philadelphia, PA 19141 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is Ruby L. Steppe/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ò 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 6/9/2007 Brentwood, MD infury (4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Socice License 22. Name and Address of FacilityFort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 6 NGESTIV /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed burial-trans Due to (or as a consequence of): P.O. Box 68760 nding physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 ☐ Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Tes 2 ☐ No 3 robably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes te hronic 2□ No 1□ Yes 2 🗆 💢 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2**N**0 1 ☐ Yes 1 mpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day , Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 1 Constituting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

DHMH 17 Rev 1/2001

State Registrar

29b. Signature and title of certifie

MID filed (Month, 32. Registrar's Signat JUN 0 7 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

MD

29c. License number

29d. Date signed (Month, Day, Year)

			For	State of		yland / De	partment o	f Healt	th and N			•	9.		~ 1 A
			1 - State Registrar			C	ertificate d	of Dea	th		Reg. No.	c.UJ	1	1 1/	9 1 -
Ė	Physici /Medic		1. Decedent's Name (First, Midd Lillian	L.			Jessie			2. Date of D May 28	eath 200	07 ^{Ye}	ar	3. Time o	of Death DPM
ķ	Examir		4a. Facility Name (If not institution		,		4b. City, Tow		tion of Death			County of E			
	er en secondos en como		Heritage Harl		,		Annap		-1-0411-			nne Ai		_	
	Funeral Director		5. Social Security Number 116-30-1717	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. last birtho	Months Da		nder 24 Hrs. urs Min.	8. Date of Bi (Month, D Sept.	orth av. Year 6, 19	919	Birthpla Countr Ne	ice (State ry) W Yo	or Foreign rk
	and w		Usual Residence of Decedent 10a. State 10b. County	,	1	0c. City, Town o	Location						10	d. Inside C	City Limits
	Mary f sho ied a	ō	Maryland Anne	Arunde1		Annapo	is								2 □ No
	the 28a-	Directo	10e. Street and Number				10f. Zip Cod	le			10g. Citi	zen of What	t Countr	y?	
	h with	i Di	2700 South Have	en Road			21	401				U. S.	. A.		
	death	Funeral	11. Marital Status	12. Was Dec	edent Ev	er in U.S.	3. Was Decedent If Yes, specify (of Hispanie	c Origin? (Sp	pecify Yes or N	0-	14. Race - A	America		
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Mar 3 █ Widowed 4 ☐ Divorced	I If Vac Gi	orces? 2 X No ive Dates:		1 ☐ Yes 2X☐		ecify:	nican, etc.)		Black, V Specify:		ite	
2-0036	72 hou "natura dical E	eted	15. Deceder (Specify only highe	nt's Education est grade completed))	16a. De	cedent's Usual Ocive kind of work do e. DO NOT use re	cupation one during	most of work	king	16b. Kii	nd of Busine	ess/Indu	ıstry	
2121	d withir giene. er than the Me	Completed	Elementary/Secondary (0-12) 12 Years	College ((1-4or 5+)		Accounta		_		Woo	olwort	th C	ompai	ny
Maryland	e d al	Be	17. Father's Name (First, Middle					18. N		e (First, Middle e Danis		Surname)			
<u>₹</u>	should be ind Mental s marked or umatic eve	မ	Samuel Roses 19a. Informant's Name/Relations			19b M	ailing Address (Sti	oot and N				r Town Sta	to Zin (Cada)	
	ges 1 and 2 should it of Health and Men If item 27 is marke or other traumatic		Lawrence S. Je		n		3 Valley								401
Baltimore,	ages 1 ant of He		20a. Method of Disposition 1 XBurial 2 ☐ Cremation		State	cemetery,	sposition (Name or crematory or other vid Ceme	place)	5/31/	Date / 2007		cation - City			York
altin	permit. Pages ' Department of H Important: If ite any injury or of		4 ☐ Donation 5 ☐ Other (3			Detii Da	22 Name and Ar	Idrass of F	acility					,	
m	any me		Donald (Hotel	tem	yes_	Edward S 1091 Roc	age⊥ kvill	Funera e Pike	a⊥ Dire e. Rock	ction ville	i, inc	:. vla:	nd 2	0852
Г	15		23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that	caused in	e death. Do not							_	Approxima Interval Be	
	Physician		Immediate Cause (Final disease or condition				dent Dia						8	Onset and	Death
	/Medical		resulting in death)			consequence of):	dent bia	0000							
	Examiner	L	Sequentially list conditions,			c Stenos	is								
	ed isit	Examiner	cause. Enter Underlying Cause (Disease or injury	S		consequence of):	T 0								
II	be executed ician and burial-transit	xan	that initiated events resulting in death) Last			ry Tract consequence of):	Infecti	on					+		
60,		E E			neum										
687	ficate physics the	edic		d	meam	onia							1		
X	The law requires that the death certificate the has been signed by the attending phys bage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou							2	23d. Date of	deliver	y	
ň	death e atte	icla	in the past 12 months? 1 ☐ Yes 2 🕅 No	4☐Pregi	nant at tir	☐ Fetal death ne of death	3 □Ectopic pregn 5 □ Other (specif					Month		Day	Year
P.O. Box	v requires that the dibeen signed by the should be detached	hys	9 🗆 Unknown	9□Unkn	nown										
	es tha gned be de	by F	Part II. Other significant condit Alzheimer s	-		not resulting in th	e underlying cause	given in F	Part I.			se contribut			
Vital Records,	requir sen s rould		Alzheimer s	Dementia	•					1 [_	Yes 2 	No 3	Proba	bly 4 X	Unknown
ပ္သ	law as b	Completed								24a. Was	psy	prior	to com	sy findings	available cause of
E	The lav cate has	Son								perl 1⊟ Yes	ormed? 2 ♣ No	deat 1 □	h? Yes 2	2□ No	
VII	ictan; Th certificate rector, pag	Be	25. Was case referred to medica examiner?	Hospital:			5			th (Check only					
	Physical this call direct	은	1 ☐ Yes 2 📉 No 27. Manner of Death	28a. Date		2 ER/Outpa	Helli 3 DOX		Nursing H	ome 5 Res			Specify)		
L C	ding I. After funer	io	Natural 5 ☐ Pendi	/A 4 a u	nth, Day	/ear) 200. Till		njury at Work? 1 □ Yes	2 🗆 No	28d. Describe	now injur	y occurred			
Division or	death death cctor: y the	ficat	3 Suicide 6 Could	not be 28e. Place	e of injury	- At home, farm	street, factory, off			28f. Location	(Street and	d Number o	r Rural	Route Nu	mber.
2	tal or / rs after al Dire	Certification:	4 [Tromicide	- Dulid	ding, etc.					City or To	own, State)			
	To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, p.	edical	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ng Physician: To the I Examiner: On the b and man	e best of a basis of ea nner state	xamination and/o	eath occurred at the rinvestigation, in the	e time, da ny opinion	te and place , death occu	, and due to the rred at the time	e cause(s) e, date and	and manne place, and	er as sta due to	ited. the cause	(s)
	To the within To the Comple	Me	29b. Signature and title of certific	ary A A			29c. Lic	ense num	ber		29d. Dat	e signed (M	fonth, D	ay, Year)	
1			2 Tedal	400,1	k D	1	D0	05868	33		Мау	29,	200	7	
,	-		30. Name and address of person Richard Osei	who completed caus	se of dea	th (Item 23a) (Ty	oe, Print) 344 W. U	niver	sity	Blvd.,	# 326			Sprin 0901	ng.

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUN 0 5 2007

32 egistrar's Signature

Box 68760. P.O. I Division or Vital Records,

altimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certifier

ABRHUMM

30. Name and addre

31. Date filed (Mont)

TITUS

0 4 2007 gistrar's Signature

2001

person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

medi

29c. License number

Annayolis,

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician EVELYN** JOHNSON 09 07 06 0650 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS **BRADDOCK** CAMPUS CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 X F Director 214-07-4363 88 December 21, 1918 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. inside City Limits "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Completed by Funeral Director Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? One Kaylor Circle 21532 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No if Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othrany Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 **Edith Phillips** Joe Beeman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 425 Braddock Street, LaVale, Maryland, 21502 Linda Miller - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) June 12 Laurel Hill Cemetery 2007 Moscow Mills, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 East Main Street, Lonaconing, Maryland 21530 Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shopk, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedi te Cause (Final disease or condition resulting in death) Congestive **Physician** ailure month /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, signed by the attending physician d be detached for use as the buria iF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9□Unknown 9 ☐ Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2K No autopsy 2 No 1∏ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 200 No Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of After 1 28d. Describe how injury occurred Injury 1: Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled in the Funeral C completely filled in the following the second sec 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Nonnochestur 00055325

State Registrar

DHMH 17 Rev 1/2001

WONSOCK

31. Date filed (Month, Day, Year)

JUN



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

And I

Terrace

Frostburg

7-04293 Jeffi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ettrey L). Kulas	1-	For State	State	or maryiana,	Certif	icate of l	Death				j. No.		I 3 Tir	ne of Death
1	hysiciar	Re	· - 4	(First, Middle,Last)					1-1	Date of Death Month une 5, 20	Day	Year		646 hrs
/lec	Examin	er	JEFF	REY	DAVID		KULA	S o. City, Town, o	r Location of		Une 5, 20	4c. Co	ounty of De	eath	
		4			e street and number)		41	Elkton				Ced			
			7 Aurora Co		7 400	(In yrs. last	hirthday)	If Under 1 Ye	ar If Under	24Hrs. 8	B. Date of Birt	h(MM/DD	/YYYY) 9	. Birthplac oreign	e (State or
F	Funeral	1	. Social Security N					Months Da			SEPT.		١, ٠	Country)	L
Ľ	Director	- 1	222-80-63		M 2 F	27	Yrs.								
. 4 . 4 40 00			Isual Residence of	Decedent 10b. County		10c. City, To	own or Location	on						10d.	Inside City Limits
	w any	1	0a. State					TON						1	Yes 2 XXNo
0	death with the Maryland or items 23a or 28a-f show must be notified at once.	ē.	MD	CECIL				10f. Zip Code			1	0g. Citize	n of What	Country?	
7	Mary 28a- ed at	Director	10e. Street and Nu		•				21921		1-	U	S.A	•	
_	h the			ORA COURT	12. Was Decedent	Ever in U.S	. 13. Wa	s Decedent of	lispanic Orig	in? (Spec	cify Yes or No)- 1·	4. Race - A		ndian, Black,
	th wit	Funeral	11. Marital Status 1 V Verer Marr	ied 2 Married	Armed Forces	?	l II Y	es, specify Cub			ican, cto.,			T 1T	CT 9717
	or it	E	3 Widowed		d If Yes, Give Year	XXVo		Yes 2 XX					specify: nd of Busii		ITE
	rs afte ural" mine	9	15. Decedent's E		only highest grade cor		16a. Deceder	nt's Usual Occu	pation (Give life, DO NOT	kind of wo use retire	rk done d)	1	CERTA		
	2 hou "nat	ompleted	Elementary/Sec		College (1-4 or	5+)							LF-EM		
5-0036	hin 7 than edica	힏			2		STAND-	-UP COM	LI) LAN	r's Name (First, Middle,				
0	sd with year of the M	S	17. Father's Name	e (First, Middle, Las	st)										
215	ntal H rked	Be	FRANC	IS L. KUI	LAS, JR.		10h Mailir	ng Address (S	treet and Nur	mber or Ru	SUE Moural Route No	mber, Cit	y or Town	, State, Zij	Code)
2	d Me	은		Name/Relationship		muen		URORA C				1021			
Ş	d 2 sh lth an n 27 i		FRANCI 20a. Method of D	S L. KUL	AS, JR./FA	200.1	Place of Dispo	sition (Name o	f cemetery,		Date	20c. L	ocation -	City or To	wn, State
ā	s l an of Hea of itel		1 XXBurial 2	Cremation	Removal from S	state i	crematory or c		DV	06/	11/200	7	WILM	INGTO	N, DE
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after 1 bepartment of Health and Mental Hygiene. Department of Health and Mental Hygiene important, or items 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner	1	4 Denotion	5 Other Spec	ifv:	CAT	HEDRAL 22.	Name and Add	ress of Facili	ity	TI/ ZOC				
<u>=</u>	rmit. epartr nport		1 1 1	Funeral Service Lic		840								DE 1	9720
	S O E E	_	M-	the disease or co	mplications that cause	ed the death	. Do not enter	the mode of d	ing, such as	cardiac or	r respiratory	arrest, sho	ock, or hea	nrt	Between Onset and
	√ysician /Medica		failure. List	ofly one cause on	each line. Alcohol a	and clo	nazepam	intoxica	tion						Death
	Examine		Immediate Caus or condition resu	e (Final disease	a. Due to (or as a cor				-						
					b.										
		ē	Sequentially list if any, leading to	immediate	Due to (or as a co	nsequence (of):								
·		Examine	(Disease or inju	nderlying Cause ry that initiated	C. Due to (or as a co	nsequence	of):								
pr	cuted and transit	EX	events resulting	in death) Last	d										
			X UNPEND	ED	#Z3a.27	28a-f	nerME o	868 6/2	1/07 TT					f delivery	
	60, ate be exe shysician	Jed J	IF FEMALE:		23c. If yes, out	tcome of pre	onancy	Fetal death		onic pregn	ancv	23	3d. Date of Month	Da	ay Year
	876 rtifical	ror use as the	23b. Was deced past 12 mo	ent pregnant in the nths?	Decapor	n it at time of c		Fetal death Other (Specif		opic progri	anoy				
	Box 687(e death certifica the attending p	or use	1 Yes 2	No 9 Unkr			5	Other (Specif	,,						of death?
	Be des	ched to	Part II Other s	ignificant condition		leath but not	t resulting in t	he underlying c	ause given in	Part I.					ne cause of death? ably 4 Unknown
	that t	detac													opsy findings availab
	S, F quires	ad blu									a	Vas an autopsy		prior to c	ompletion of cause of
	ord w rec	shor										erformed es 2	No No	death? 1 ✓ Ye	s 2 No
	Rec The la	page	5					2	6.Place of De	eath (Chec	k only one)				
	ian:	ctor,	25. Was case examiner?	referred to medical		patient 2	ER/Outpa		Other		sing Home		idence 6		: Scene
	Vit hysic this	l dire	O 1 V Yes	2 No			28b. Time		8c. Injury at V	Vork?	28d. Desc	ribe how	injury occu	rred	
	of ing P	funera			28a. Date of (Month,) Ting Fnd 6/		Fnd '	3:30 pm	1 Yes 2	No X	unk				
	ion ttend death.	y the	2 Accide	ent Inves	stigation 28e Place	of Injury - A	t home, farm,	street, factory,	office buildin	ng, etc.	28f. Loca	tion (Stree	et and Nur	nber or Ru	ral Route Number, C
	Division of Vital Records, P.O. taal or Attending Physician: The law requires that the safter death. In Director: After this certificate has been signed by all pirector: After this certificate has been signed by	dinb	1 Natura 2 Accide 3 Suicid 4 Homio	dete	rmined (Specify)	reside	ence					_	Elk		
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician.	y filler		cide				occurred at the	time, date ar	nd place, a	and due to the	e cause(s) and man	ner as stat	ed. ne cause(s)
	he Ho in 24 l	pletel	(Check only one)	2 Medical Exa	miner:On the basis of	of examination	on and/or inve	Sugation, in my	ор		ed at the time.				onth, Day, Year)
	To ti withi	COM	7 1	e and title of certific	and manner of	aleu.		290	: License nur	mber		12	ad. Date c	9.10- (mur, Day, rear
	_		_ (la sai	OHA.	e Qa	u		O.C.M.E			3%3	lune 6, 1		
			20 Nama ca	d address of person	n who completed caus	se of death (Item 23a)				004				
	_			Allan, MD As	ssistant Medical	Examine	r III-e	enn Street,	Baltimore,	, MD 21	201				
(<u> </u>	0,		(Month) PRI Year	5 2007 32. 5	gistrar's Sig	nature	Coule	,						

Registrar

7-04477		Please Type or						gibie.		
Deangela J Kittrel			f Maryland / Dep				i Hygiene	6	9 8 7 1 6 B	
	F	- For State Registrar	Ce	rtificat	e of Death			eg. No.		1.0 (40)
Physiciar	-	Decedent's Name (First, Middle,Last)					Date of Deam Month	Day Yea	3. Time of Death	
Medical Examin		Deangela	J		Kittre		June 11, 2	2007		_
	1	4a. Facility Name (If not institution, give s				wn, or Location of D	Death	4c. County of Prince G		
		Prince George's Hospital Ce			Chever					_
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthd	ay) If Under Months	1 Year If Under 2 Days Hours	Min.	,	9. Birthplace (State or Foreign Washingt	0
Director	7	214-17-7815	1 2X F 20		Yrs.		02/01	1/1987	Country) D.C.	
	* **	Usual Residence of Decedent	1100 00	y, Town or	Location				10d. Inside City Limits	_
w any		10a. State 10b. County		y, TOWITOI					1 X Yes 2 No	
Maryland 28a-f show d at once,	₫[Maryland Prince	George		Clin			0g. Citizen of Wh		
the Mary a or 28a tiffed at	9 I	10e. Street and Number			10f. Zip C		l'			
h the		11412 Brandywin				735		USA		_
in wit	unera	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Ever in I Armed Forces?	J.S. 1		t of Hispanic Origin Cuban, Me xican, P	? (Specify Yes or No uerto Rican, etc.)		e - American Indian, Black, e, etc.	
r deal or it	ᇍ		1 Yes 2 X No		4 No. 10	V 10		Connifu	Dlagl	
s afte	ᇍ	3 Widowed 4 Divorced	Yes, Give Year or Dates:	1162 Do	1 Yes 2	ccupation (Give kir	nd of work done		Black usiness/Industry	
hour natu	티	Elementary/Secondary (0-12)	College (1-4 or 5+)			ng life, DO NOT us		TOD: Tand of Do	active contracting	
36 in 72 ban '	<u>b</u>	12	College (1-4 of 51)		Homema	ker		Dome	stic	
-00 I with giene ther t	Completed	17. Father's Name (First, Middle, Last)					Name (First, Middle,			_
al Hy red of	8	Anthony		V:++	rell	LaVe	rne		Dreher	
212 uld buld buld bulld	2	19a. Informant's Name/Relationship (Typ	e, Print)	19b.	Mailing Address		er or Rural Route Nu	mber, City or Tow	vn, State, Zip Code)	
Baltimore, MD 21215-0036 pernit Pages I and 2 should be filed within 72 hours after deain with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		Anthony Kittrel	1/ Father	18	307 Sum	ter Rd.	Culpeppe	er,Virg	inia 22701	
e, had I and Healt item		20a. Method of Disposition	20b	. Place of	Disposition (Name y or other place)		Date		- City or Town, State	
10r ages nt of t: If		73	Removal from State			riol	6/19/07	Landos	ver Marvland	1
Itin Partment Partmen	ŀ	4 Donation 5 Other Specify: 21. Signature of Funeral Service License	na ne	L IIIOI.	22. Name and A	Address of Facility	Adams Fi	neral	ver,Maryland Home PA	_
Deput Deput	ŀ	Flux Of	1 _	91					ryland 2060	
Physician	7	23a. Part I. Enter the disease, or complic	ations that caused the dea	th. Do not	enter the mode of	dying, such as car	diac or respiratory ar	rest, shock, or he	eart Approximate Interval Between Onset and	al
/Medical		failure. List only one cause on each immediate Cause (Final disease a.	Complications o	f bloc	d loss				Death	1
Examiner			ue to (or as a consequence		A 1000					
		Sequentially list conditions,	Subinvolution o		ental site	2				
	Examiner	if any, leading to immediate D cause. Enter Underlying Cause	ue to (or as a consequence	of):						
	E	(Disease or injury that initiated events resulting in death) Last	ue to (or as a consequence	of):						
executed an and al - transit	٩	d								
e exec iian ai	ig a	X UNPENDED	^₩ 5 \$5 - b, 27, pe	rME. 08	869. 7/20/0)7 TT				
Box 68760, he death certificate be the attending physicine the attending physicine for use as the burned for u		IF FEMALE:	23c. If yes, outcome of pre		, , , , , ,			23d. Date of	f delivery	_
687 ertific ding 1	an/	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2	Fetal death		pregnancy	Month	Day Year	
OX ath c	sici	1 ✓ Yes 2 No 9 Unknown	4 Pregnant at time of Unknown	death 5	Other (Speci	ify)		Jun 4,	, 2007	
the de	튑	Part II. Other significant conditions		t resulting	in the underlying	cause given in Part	11. 23e. Did	tobacco use cont	ribute to the cause of death?	_
Division of Vital Records, P.O. Box ral or Attending Physician: The law requires that the death rrs after death. "In Director: After this certificate has been signed by the atte life in by the funeral director, page 2 should be detached for the contract of the contract	盃		y		, ,			s 2 No 3	Probably 4 🗸 Unknown	1
duld be	ompleted						24a. Was		Were autopsy findings availab	
Orc aw re nas be	릙						auto		prior to completion of cause of death?	
Zec The I cate	힝							2 No 1	1 Yes 2 No	
ian: certif	Be	25. Was case referred to medical examiner?	enital:			6.Place of Death (C		1		
Nysic Physic al dire	힏	1 ✓ Yes 2 No	spital: 1 Inpatient 2		patient 3 DC		Nursing Home 5	Residence 6	Other:	
After fumer	崩	27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	286. 11	ime of Injury 2	8c. Injury at Work?		how injury occur	rred	
ttend death ctor:	ä	2 Accident Pending Investigation	1					/O:	David Barta Marker (iii	A
ivis or A after Dire	ij	3 Suicide 6 Could not b		home, far	m, street, factory,	office building, etc	or Town,		ber or Rural Route Number, Ci	ty
Spita hours neral	Certification:	4 Homicide	(Specify)				1			_
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	cal	(Check only one) 2 Medical Examiner:	n: To the best of my knowledge the basis of examination	edge, deat n and/or in	h occurred at the vestigation, in my	time, date and place opinion, death occi-	ce, and due to the cau urred at the time, date	use(s) and manne e and place, and	er as stated. due to the cause(s)	
To tl withi To tl	Medical	29b. Signature and title of certifier	and manner stated.			License number			ned (Month, Day, Year)	
	-	250. Signature and title of certifiel	x/01 20		250.	O.C.M.E.		June 13, 2		
		arol	Hall	ノい		J. J. H. L.				
100		30. Name and address of person who co Carol Allan, MD Assistar	ompleted cause of death (It it Medical Examiner		Penn Street F	Baltimore, MD	21201			
DU			A				20	<u>.</u>		_
Sta Registi	ate	31. Date filed (Month, Day, Year) 5 2	32. Fegistrar's Sign		Spark					

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

þ

Completed

ပ္

Examine

Physician/Medical

ģ

Completed

Be

ျ

Certification:

Medical

r than

. Pages 1 and 2 should be file tment of Health and Mental Hi tant: If item 27 Is marked oth

Department of Important: If it any Injury or o

Physician

Examiner

attending physician and for use as the burial-tran

signed by the at d be detached fo

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

within 2

Division or Vital Records, P.O. Box 68760,

/Medical

3altimore, Maryland 21215-0036

1. Decedent's Name (First, Middle, Last) Sylvia B. Kaplan 4a. Facility Name (If not institution, give street and number) 5. Social Security Number 6. Sex 067-14-8204

10b. County

Montgomery

15. Decedent's Education (Specify only highest grade completed)

1801 E. Jefferson Street, # 326 7. Age (In yrs. last birthday) 1 □ M 2 □ F 86

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates:

College (1-4or 5+)

4b. City, Town, or Location of Death Rockville Months Days

Yrs

10c. City, Town or Location

8. Date of Birth (Month, Day, Ye Dec • 24, If Under 1 Year If Under 24 Hrs. Hours

2. Date of Death

Month

June

4, 2007 4c. County of Death

Day

5:30 P. M

Montgomery 9. Birthplace (State or Foreign Year) 1920 New York

3. Time of Death

10d. Inside City Limits Yes 2 □ No

Rockville 10f. Zip Code 10g. Citizen of What Country? U. S. A.

20852 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

14. Race - American Indian Black, White, etc. Specify: White

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

Bookkeeper

vastula-

1 ☐ Yes 2 No

Community College 18. Mother's Name (First, Middle, Maiden Surname)

17. Father's Name (First, Middle, Last) Moisha Brody

3 ☑ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

12 Years

20a. Method of Disposition

19a. Informant's Name/Relationship (Type. Print) Sherri B. Deck - Daughter

1

☐ Paurial 2 ☐ Cremation 3 ☐ Removal from State

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1618 Auburn Avenue, Rockville, Maryland Date

Ida Sadofsky

20b. Place of Disposition (Name of cemetery, crematory or other place) Eternal Light Cem.

6/7/2007

Boynton Beach, Florida

20c. Location - City or Town, State

21. Signature of Funeral Service License

Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland 20852

23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Atheroscleratio

Immediate Cause (Final disease or condition resulting in death)

4 Donation 5 Other (Specify)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of).

Due to (or as a consequence of):

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

Day

IF FEMALE 23b. Was decedent pregnant in the past 12 months? ☐Yes 2 No 9 Unknown

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

9□Unknown

3 □Ectopic pregnancy 5 Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Tyes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performe 1∐ Yes 2th No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25.		case	referred	to	medical
			2/21 No		
27.	Mani	ner of	Death		

1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year)

10200

2 ER/Outpatient 3 DOA 28b. Time of Injury

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Road Columbia, MD 21046

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one)

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c, License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wilks 31. Date filed (Month, Day, Year) 06 2007 JUN

old 32. Registrar's Signature

State Registrar Columbia

		_	For State Registrar	State of Mary		artment of H <i>rtificate of L</i>			giene Reg. No.	2017	10922
Phys	sicia	100	1. Decedent's Name (First, Middle, Las	st)				2. Date of De	ath Day	Year	3. Time of Death
/Me	edic	al .	Bennie Ra 4a. Facility Name (If not institution, give	ymond Kittre	e11	4b. City, Town, or	Location of Death	June	2	2007 County of Death	10:38P M
Exa	mine	er	Southern Mary		a 1	45. Ony, 10411, 61	Clinton		40.0		George's
Fune	ral		5. Social Security Number 6. S		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da	h y, Year)		lace (State or Foreign
Direct	or		239-68-9552 Usual Residence of Decedent	tal vi zu i	53 Yrs.			July 28	, 19	43 North	Carolina
yland now at			10a. State 10b. County	100	c. City, Town or Lo	cation				. 1	0d. Inside City Limits
e Mar 3a-f sk tified		ctor	Maryland Prince	George's		Temp]	le Hills				1MTYes 2□No
vith th r or 28 be no		Directo	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Coun	try?
eath v		Funeral	4649 Dallas	Place, #202		Was Decedent of Hi	20748 spanic Origin? (Sp	ecify Yes or No	.] 1-	United 4. Race - Americ	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tien Z1 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		2	1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specity Cuba l □ Yes 2덨 No	n', Mexican, Puèrto Specify:	Rićan, etc.)		Black, White,	etc. Bla c k
5-0 72 ho "natur dical		Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	lent's Usual Occupa kind of work done o	luring most of work	ing	16b. Kin	d of Business/Inc	dustry
within ene.		dmo	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	iiie. L	OO NOT use retired,				Desire	4.0
d 2 filed Hygi other		Be C	17. Father's Name (First, Middle, Last)			Truck	Driver 18. Mother's Name	e (First, Middle,	Maiden S	Priva Surname)	re
Maryland d 2 should be file th and Mental Hy ?7 is marked oth traumatic event		일	Ned Kittre	11				Ar1e	tha :	Best	
Aar 2 sho and is ma			19a. Informant's Name/Relationship (g Address (Street a					*
e, h 1 and 1 and Health em 27			Deborah L. Kitt 20a. Method of Disposition		0b. Place of Dispo	1649 Dalla sition (Name of		Date		HILLS,	
timore, . Pages 1 al tment of Hez tant: If item			1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			natory or other place Semorial (1	2007	Sı	uitland,	MD
alti rmit. ppartm porta y inju	Ge		21. Signature of Funeral Service Licer			. Name and Addres				ral Home	
0 88 5 8	9		10m/S	leward III			enning Rd			., DC 20	
Physicia	an		23a. Part1. In ter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or you flion	one cause on each line.		er the mode of dying)	Approximate Interval Between Onset and Death
/Medic Examin			resulting in health)	Due to (or as a cor		-					
		je.	Sequentially list conditions,	b. Due to (or as a cor							
ecuted ind transit		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Ÿ	در هده	9~	bolon				
68760, ficate be exemply sician a		E E	resulting in deathy cast	Due to (or as a cor	nsequence of):						
687 ifficate g phys		edical		⊾d							
Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit		Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23	3d. Dat <i>e o</i> f d <i>e</i> live Month	ery Day Year
dS, P.O. ires that the de signed by the a			Part II. Other significant conditions of	ontributing to death but no	t resulting in the ur	nderlying cause give	en in Part I.	23e. Did t	obacco us	e contribute to the	e cause of death?
Vital Records, sician: The law requires the certificate has been signe rector, page 2 should be d		ed by						1 🗆 '	Yes 2□]No 3□ Prob	ably 4 Unknown
law reas been 2 sho	1	Completed						24a. Was		24b. Were auto	psy findings available mpletion of cause of
								perfo 1⊟ Yes	rmed? 2 No	death?	2 No
Vita siclar certifi rector		Be	25. Was case referred to medical examiner? 1 No	Hospital:	MIED/Outrobion	• all DOA Othe	26. Place of Deat			7	
g Physer this eral dil		n: To	27. Manner of Death	1 Inpatient 28a. Date of Injury (Month, Day Yea	2X ER/Outpatien 28b. Time of			28d. Describe I		Other (Specify occurred	/)
ending Feath.		atio	1 Natural 5 Pending investigation			M 1 1	Yes 2 □ No				
DIVISION OF HOSPITAL or Attending Physical Attending Physical Cath. Full hours after death. Full hours after this inetely filled in by the funeral difficial in the funeral difficial in the funeral d		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - building, etc. (S	At home, farm, stropecify)	eet, factory, office		28f. Location (S City or Tox	Street and vn, State)	Number or Rura	l Route Number,
Division or Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, p		Medical	29a. Certifier Certifying Ph (Check only Medical Exar	ysician: To the best of my niner: On the basis of exa and manner stated.	y knowledge, death mination and/or in	vestigation, in my of	pinion, death occur	and due to the red at the time,	cause(s) a date and	and manner as si place, and due to	ated. the cause(s)
2 2		Σ	29b. Signature and title of certifier	- >		D64	number 055		29d. Date	signed (Month,	Day, Year)
Ek	0		30. Name and address of person who ERIC McDonall	mD 750	3 Surrf	ALLS RI	. Clint	ton, n	vd	2073	5
Reg	Stat istra		31. Date filed (Month, Day, Year) JUN 0 8 200	32. Registrar's S	signature	ريو					
DHMH 17 Rev			JOH 0 0 200	· position	13. What						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2, 2007 3:15 June p Grace Torre Kelly 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Montgomery
9. Birthplace (State or Foreign
Country)

Year)

York 10014 Frederick Avenue Kensington Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number Days Hours Months 1 □ M 25€ F 092-10-3116 89 29 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 √Yes 2 No Maryland Kensington Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20895 USA 10014 Frederick Avenue 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married SpecifyWhite 1 □ Yes **XX**No Specify: 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Administrative Assistant Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Concetta Schepis John Torre 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kathy Bransford / Daughter 3317 R Street, NW, Washington, DC 20007 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition June 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 4 □ Donation 5 □ Other (Specify) 2007 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22 Name and Address of Eacility Francis J. Collins Funeral Home Inc.

Physician **...** /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

Directo

Funeral

ģ

Be Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eximiner must be notified at once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

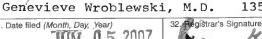
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

	/aux	2000		niversity Bly		ver Spring				
	23a. Part1. Enter the disease, or co shock, or heart failure. List or	complications that caused the death. Do not only one cause on each line.	t enter the mod	de of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death			
	Immediate Cause (Final disease or condition resulting in death)	sease or condition a Malianant Neorlasm of Kidney								
niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b								
ical Exar	that initiated events resulting in death) Last	c	C							
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23b. Was decedent pregnant in the past 12 months? 1								
d by Ph	_	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.								
omplete					24a. Was an autopsy performed?	? death?	opsy findings available ompletion of cause of			
De C	25. Was case referred to medical			26. Place of Dea	th (Check only one)					
	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	oatient 3 □ D	OA Other: 4 Nursing H	ome 5X Residence	6 □Other (Speci	ify)			
ation: I	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day Year) 28b. Tir Inju	njury occurred							
Medical Certification: To	3 ☐ Suicide 6 ☐ Could no 4 ☐ Hornicide determin		and Number or Rur ate)	al Route Number,						
dical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	g Physician: To the best of my knowledge, Examiner: On the basis of examination and and manner stated.	death occurred for investigation	d at the time, date and place on, in my opinion, death occu	, and due to the cause rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)			
Ŋ	29h Signature and title of certifier	1100	29	9c. License number	29d. I	Date signed (Month	, Day, Year)			

State Registrar 31. Date filed (Month, Day, Year) 2007 05 JUN

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D064615

2007

June 4,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State o	of Marylan	•	artment of H tificate of L			giene Reg. No.	37	19924	
			Decedent's Name (First, Middle, Last)						2. Date of Dea		Vans	3. Time of Death	
	Physicia		Myrtle Virginia	Kline					Month	Day	Year	925 DM	
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and nu	ımber)		4b. City, Town, or	Location of Death			ty of Death		
	LACITIII	٠,	St. Thomas Moore	Mursi	na Home		Hvat	tsville		Princ	e Geo	rge County	
	Funeral		5. Social Security Number 6. Sex		7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs.	8. Date of Birti (Month, Day	h		lace (State or Foreign	
	Director		217–18–7185 ^{1□}	M 22 F	94	Yrs.	Months Days	Hours Min.	Dec 7	1912		ginia	
			Usual Residence of Decedent										
	ylan how		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				1	Od. Inside City Limits	
	B-f s	101	Maryland Washin	gton		Ha	gerstown					1 ☐ Yes 2 💆 No	
	h the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o	What Cour	itry?	
	death with the Maryland ms 23a or 28a-f show r must be notified at		14014 Marsh Pike				2	21742			U.S.	Α	
	dea	Funeral	11. Marital Status	2. Was Dec Armed F	edent Ever in U	.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No- o Rican, etc.)		ace - Amend ack, White,		
٥	or its		1 Never Married 2 Married		24 No		1 ☐ Yes 2Ã No	Specify:		Spec	T ₄ 7h	ite	
2-003p	ours irel',	d by	3 Widowed 4 □ Divorced	Year or [
	72 h	Completed	15. Decedent's Educ (Specify only highest grade)	16a. Deced	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wo	rking	16b. Kind of	Business/Inc	dustry	
Z	ithin ne. han	ďμ	Elementary/Secondary (0-12)	College (1-4or 5+)		emaker	1)		Pers	onali	Residence	
7	e filed within al Hygiene. I other than " went, ii w Ma		17. Father's Name (First, Middle, Last)			110111	- I	19 Mothade Nor	ne (First, Middle,			COTGCIOC	
/land	s 1 and 2 should be filed within 72 hours after death with the Marylan if Healith and Mantal Hygiene. If Healith and Mantal Hygiene is the file of its marked other than "neturel", or itams 23a or 28a-f show other traumatic event, Ita Maulcal Eracified and other traumatic event, Ita Maulcal Eracified and other traumatic event, Ita Maulcal Eracified	Be	Charles Melvin S	hinala	ton				na Gertri				
<u>}</u>	ould Mer narke	ဥ			COII	401 14 75						Codel	
<u>g</u>	12 sh and ris n	9 4	19a. Informant's Name/Relationship (Type	•					Rural Route Number, City or Town, State, Zip Code)				
	l and lealth im 27		David Charles Kline 20a. Method of Disposition	e sor			hallenger	Court W	/alkersv	LITE Ma 20c. Location			
0	Pages 1 nent of H int: If ite iry or ot		Burial 2 Cremation 3 R	emoval from	Ctata C	cemetery, crer	natory or other place en Cemete	e) Arv Tune	5 2007			Maryland	
altimore,			*4 □ Donation 5 □ Other (Specify)	_	Re			- ;	12.				
g	parmit. Departr Importe any inje		21. Signature of Funeral Service License	100	17.	22	2. Name and Addres	ss of Facility DC	ouglas A.	Fiery	7 Fune	ral Home	
_	70 = 8 Q		() lluyes	1	Sury		331 Easte	ern Blvd.	N. Hage	erstown	Mary	7 and 21742 Approximate	
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	e cause on.	caused the deal each line.	th. Do not ent	er the mode of dyin	g, such as cardiad	or respiratory ar	rest,		Interval Between Onset and Death	
7	Physician	8 6	Immediate Cause (Final disease or condition	Ar	terio	scher	otic Ca	ndioVa	scular	Dive	965	year.	
	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):						1	
	Examine		Sequentially list conditions.		With the control of t	DVSCASO UM					_		
_	p ii	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Duato	(or as a consec	uanea of):							
	and and -trans	Examin	that initiated events resulting in death) Last	. Due to	(or as a consec	uence of):							
Ď,	be exacuted ician and burial-transit			Dus to	(0) 23 2 00/1300	(barroa or).							
9/8 8/90	ate the	dlcal	d										
و ×	death cartific e attending p id for usa as	a a	IF FEMALE:	30 If yes or	utcome of pregn	ancv				724 [ate of delive		
X Q Q	ath c attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 🗀 Live	birth 2 Fets	al death 3	Ectopic pregnancy Other (specify)	,			Date of delive Month	Day Year	
:	the de y the a	Physician/M	1 ☐ Yes 2 ☐ NO 9 ☐ Unknown	9□ Unki	nant at time of one of the communication of the com	19am 5 L	_ Other (specify)						
J.	that the de ned by the a detached f		Part II. Other significant conditions con	tributina to o	death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use co	ntribute to the	ne cause of death?	
ď,	86 196	l by	Cerebral thur	المراب	F.JC	•			10	res 2□No	3 ☐ Prob	ably 4 Dinknown	
Ö	w require been si should b	Completed	COFFE	.,,,	7				040 460	041	Mara auto	nov findings available	
ē	Tha law cate has t page 2 s	ďu	Dementa						24a. Was autop	an 240 sy rmed? •	prior to co death?	psy findings available mpletion of cause of	
=	cate pag	ပ္ပ								2 No	1 Yes	2 □ No	
Vital Record	itcien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:			Oth	/	ath (Check only o				
5	Physicien: r this certifica ral director, p	2	1 Tes 2 No	1		ER/Outpatier 28b. Time of	it 3 DOA	4 Inursing F	lome 5 Resid			y)	
	ding F h. After funer	o	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date (Moi	nth, Day Year)	Injury	Wor	k?` Yes 2⊟No	Loa. Bosonbo	ion injury occ	unou		
S	teat for: the	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	29a Plac	e of Injury - At h	iome farm str		103 2 110	28f. Location (Street and Nur	nber or Rura	I Route Number,	
DIVISION	or Atten after deat Director: In by the	Certification:	4 ☐ Homicide determined	build	ding, etc. (Speci	fy)	reet, factory, office		City or Tov	vn, State)			
_	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Phys	sician: To th	ne best of my kn	owledge, deat	h occurred at the tir	ne, date and place	e, and due to the	cause(s) and	manner as s	tated.	
	Hos 24 hc Fun stely	edical	(Check only 2 Medical Examination)	ner: On the	basis of examination	ation and/or in	vestigation, in my o	pinion, death occu	urred at the time,	date and place	e, and due to	the cause(s)	
	o the	Me	29b. Signature and title of certifier	0			29c. Licens			29d. Date sign			
	- s + ō		Man Oan	(11)	Just	(n)	SCK	0185	2	JUN	E 2	2007	
			30. Name and address of person who co	mpleted car	use of death (Ite	m 23a) (Type.	Print)			4		2007 MD 2013	
St	1-4		PA1 4. B	SVOK	E 14)	420	3 Quel	usbun	nel H	yatt	will	8105 CMO	
	Sta	ite	31. Date filed (Month, Day, Year)	32.	Registrar's Sign	ature		,		/,			
	Regist		MIN A A 2	007	2	A	Fra. M. A						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mont5/31/2007 7:00 am **Physician** Margaret Beverage Kiely /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel 1017 Mastline Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2000 229-28-1804 11/10/1925 Virginia 81 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County iral", or Items 23a or 28a-f show Examiner must be notifled at Annapolis 1 ☐ Yes 2 No MD Anne Arundel Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21401 USA 1017 Mastline Drive Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes **XX**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married White 1 ☐ Yes XX No Specify: Completed by 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) f Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Civil Servant US Government 12 other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Louella Ryder Walter Ralph Beverage 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1017 Mastline Drive Annapolis, MD 21401 Joseph A. Kiely Jr. Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington, VA Arlington National 6/19/2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Servi Annapolis, MD 21401 Dain 12 Ridgely Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (as a con quence of): **Physician** years resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed burial-trai Due to (or as a consequence of) Physician/Medical the SS attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Month 4☐Pregnant at time of death 5 Other (specify) ed by the a 9☐ Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 perform certificate 1∐ Yes 2 No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A etely filled in by the fi 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

31. Date filed (Month, Day, Year)

JUN Q 4 2007

2

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

estgate Rd #303, ANNAPOlis, MD 21401

			Please Type or Prin					•		•		
			State of Maryland / Department of Health and 1- State Registrar Certificate of Death						0003 1000			
	_		State Registrar 1. Decedent's Name (First, Middle, Last)		Ce	rinicate of t	Deam	2. Date of De	Reg. No	-Z. U U 7	3. Time of Death	
ř	Physicia		Mary G. Kelly					Month May	31	2007		
		/Medical raily G. Relly (xaminer 4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			40	. County of Dea	ath	
	3 .		Heritage Harbour Health & Rehab. Ce 5. Social Security Number 6. Sex 7. Agr		irth dou	Annapoli		8. Date of Bi		Anne Ar		
Ы	Funeral Director		1□M 2DVE	e (In yrs. last bi 91	Yrs.	Months Days	Hours Min.		ay, Year)	C	rthplace (State or Foreign country) nnsylvania	
	- 10		Usual Residence of Decedent	,				00/15/	1713			
	f shoved at	ō	10a. State 10b. County	10c. City, Tow							10d. Inside City Limits 1 ☐ Yes 2 No	
	r 28a-	irect	Maryland Anne Arundel 10e. Street and Number	Annar	ротт	10f. Zip Code			10g. Ci	tizen of What C	ountry?	
	should be filed within 72 hours after death with the Maryland ind Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	Funeral Director	2700 S. Haven Road			21401			Un	ited St	ates	
	er dea	nuel	11. Mantal Status 12. Was Decedent Armed Forces?		13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or Note to Rican, etc.)	0-	14. Race - Am Black, Wh		
36	urs afte	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, 2 🕅 1 If Yes, Give Year or Dates:	40		1 □ Yes 2X No	Specify:			Specify: V	White	
21215-0036	72 hou	Completed	15. Decedent's Education (Specify only highest grade completed)	16a	a. Dece	dent's Usual Occup	pation	rkina	16b. K	(ind of Busines	s/Industry	
12	vithin me.	mple	Elementary/Secondary (0-12) College (1-4or 5	i+)	_	e kind of work done of DO NOT use retired	d)	9	\ \ \	ledical		
ק ס	filed v Hygie Sther t	ပ္ပ	17. Father's Name (First, Middle, Last)		Vurs	se	18. Mother's Na	me (First, Middle				
lan	should be filed ad Mental Hygi marked other matic event, t	To Be	Phillip Gallagher				Mary Qu	inan	-,,			
Maryland	S 60 10		19a. Informant's Name/Relationship (Type. Print)	19	b. Maili	ng Address (Street	and Number or R	ural Route Num	ber, City	or Town, State,	Zip Code)	
e, S	1 and Health em 27 ther to		Marsha Pfunder/Sister 20a. Method of Disposition			Horseman osition (Name of	Way, Day	vidsonvi Date		Mary1a		
Baltimore,	Pages nent of int: If it		1 Marial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	cemete	ery, cre	matory or other place L Cemetery		07/2007			Pennsylvania	
alt	permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service Licensee	DC: 041		2. Name and Addre						
m	88 E 8 8		Millell lille			2973 Solor				ewater,	MD 21037	
ı			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each limmediate Cause (Final	I the death. Do	not en	ter the mode of dyir	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a consequence	<u>C</u> .	MATERIA	<i>u</i> 19					
i.	Examiner		Sequentially list conditions b									
4	isit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence	e of):							
,	e executed ian and urial-transit	Examin	that initiated events	a consequence	e of):	-						
68760,	death certificate be executed e attending physician and id for use as the burial-transit	_										
	eath certificate be attending physici for use as the bu	Physician/Medica	IF FEMALE: 23c. If yes, outcome	of prognancy			-					
Box	death c	cian		2 Fetal deat		☐Ectopic pregnancy ☐ Other (specify) _	у			23d. Date of d Month	elivery Day Year	
л О	at the de by the a tached	hysi	9 Unknown 9 Unknown									
	as the	þ	Part II. Other significant conditions contributing to death b	out not resulting	in the u	underlying cause giv	en in Part I.				to the cause of death?	
Ö	w require been sign	eted	- Jacobs St. 100	ince							Probably Unknown	
Records,	sician: The law certificate has t irector, page 2 s	Completed						24a. Wa aut per	opsy formed?	prior to death?		
Vita	lan: T	Be Co	25. Was case referred to medical				26. Place of De	1 Yes ath (Check only	one)	o 1 □Y€	es 2 No	
	hysic this ce	To		ent 2 ER/O			4 Nursing I	Home 5□Res			pecify)	
Division or	ding Phy h. After thi funeral o	ion:	27. Manner of Death Natural 5 Pending Negrigant investigation 28a. Date of Inju (Month, Date)		. Time o	Wor	ryat rk? Yes 2 □ No	28d. Describe	how inju	ary occurred		
NISI N	I or Attend after death Director: /	Certification:	3 Suicide 6 Could not be 28e. Place of inj	ury - At home, f	farm, st	treet, factory, office				t and Number or Rural Route Number,		
	Ital or irs afte ral Dir led in	Cert	N									
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, g	Medical	29a. Certifier (Check only one) (Check one) (Check only o	of examination a								
	To the within 2 To the complete	Med	29b. Signature and the of certifier			29c. Licens	se number		29d. Da	ate signed (Mo	nth, Day, Year)	
			P(A)				5702	0		6-1-	01	
	Fait		30. Name and address of person who completed cause of c	leath (Item 23a)	(Type	Pro 1	23 A	mapol	-	MD.	2401	
	Sta	te	31. Date filed (Month Day, Year) JUN 0 4 2007 32. Figistr	rar's Signature		Nu. +	771		٠	- 2	, ,	
	Registr		JUN U 4 2007	m &	1	book						
DIE	MB 17 Doy 1/0	201			- 4	Control of the Contro						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Vear **Physician** 2255 M MOND 05 30 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) 02/05/1919 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Days Months Min Hours 2 🗆 F 88 Maryland Director 220-07-1011 Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Funeral Director Maryland Baltimore City Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Inent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Items 23a or 28a-10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21206 United States 4412 Ashcrest Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 X1 Yes 2 □ No If Yes, Give Year or Dates: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by Specify: 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 C1erk Baltimore City Police 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Kothe Mary Raymond ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond H. Kothe, Jr./Son 831 Shore Drive, Edgewater, Maryland 21037 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 06/01/2007 | Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician len disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9□Unknowr 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2☐ No page 2 s autopsy perform 1∐ Yes 2 No or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Inpatient 10 2 ER/Outpatient 3 DOA this nours after death. neral Director: After this y filled in by the funeral di 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? (Month, Day 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State

31. Date filed (Month, Day, Year) JUN 0 4 2007

29b. Signature and title of certifie

30 Name and address of person

EFENSE HIGHWAY ANNARUSMD ZIYU EN 32. Re Istrar's Signature

74 un. 445

who completed cause of death (Item 23a) (Type, Print

Registrar DHMH 17 Rev 1/2001 29c. License number

29d. Date signed (Month, Day, Year)

KENNETH KIMBALL Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

hysician			bea of	2/ 2/ 10
	1. Decedent's Name (First, Middle, Last) Kenneth Kay Kimball	2. Date of De Month June	Day Yea	
Medical xaminer	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of D		4c. County of De	
Adminici	Berlin Nursing & Rehabilitation Center Berlin		Worcest	ter
neral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours M	Hrs. 8. Date of Bir Min. (Month, Da	th 9. B	irthplace (State or Forei
ector	434-20-7653 87 Yrs. Usual Residence of Decedent	9/12/		NJ
at d	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limit
ctor	MD Worcester Berlin			1 □Yes 2 □
minoriam. In rening 2 is manded unter that in natural, on thems year or coart show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What (Country?
aral	23 Battersea Rd. 21811		USA	
iner must	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married	? (Specity Yes or No uerto Rican, etc.)	Black, Wi	nerican Indian, nite, etc.
Exam Exam	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No If Yes, Give 1 □ Yes 2 ☑ No Specify:		Specify:	Nhite
t, the Medical E	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working	16b. Kind of Busines	s/Industry
m pl	Elementary/Secondary (0-12) College (1-4or 5+)	5	, , , , , , , , , , , , , , , , , , ,	
ont, the	The state of the s	Name (First, Middle	US Goven	nment
atic even		arie Durfe		
umat	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of			, Zip Code)
er tra	Irene Kimball / wife 23 Battersea Rd., Be	erlin, MD	21811	
to of	20a. Method of Disposition 1 反 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City	or Town, State
luny	4 Donation 5 Other (Specify) MD Veterans Cemetery 6/	7/2007	Hurlock,	
any ir	1/ 4004 41/ 40/	III Dalbe	age Funeral	Home
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car			Approximate
report transit not build be build be build	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undership Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			(Eups.
detached for use as the detach	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 5 ☐ Other (specify) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	23e. Did t	23d. Date of of Month	lelivery Day Year to the cause of death?
should be	Monce Obstructive Polymoney DiSon	10	Yes 2 No 3	Probably 4 Donknor
Comp		1□ Yes	psy prior to death' 2 L No 1 □ Ye	
al director	examiner?	Death Check onl	one dence 6 □Other (Sp	
funeral dir	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		how injury occurred	еспу)
led in by the funera Certification:	2 Accident investigation M 1 Yes 2 No			
in by i	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (a City or Tol	Street and Number or wn, State)	Rural Route Number,
ical	29a. Certifier (Check only one) 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and p 213 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated.	lace, and due to the	cause(s) and manner, date and place, and d	as stated. ue to the cause(s)
Med	29b. Signature and title of certifier 29c. License number D2876	.9	29d. Date signed (Mo	nth, Day, Year)
541	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nickley Bradelic Lab 1207 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Heylun	y Ferwick	Toler De

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** ^{Day} 2007 June 5, Norman Lynn Laser 12:57 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. Takoma Park nder 1 Year | If Under 24 Hrs. Montgomery ige (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace Country) (State or Foreign Days Hours 1 ☐XM 2 ☐ F Months Yrs 579-46-4316 79 1928 Washington, DC Jan. 31. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1016 Ruatan Street 20903-3215 USA Funeral 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No ^{Specify:}White à Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Historian History 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Adine Pridmore Elmer C. Laser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary A. Laser/Wife 1016 Ruatan Street, Silver Spring, MD 20903-3215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date June 7. 1 Burial 2 □ Cremation 3 ☐ Removal from State Manassas City Cemetery 5 Other (Specify) 4 Donation 2007 Manassas, Virginia 21. Signature of Runeral Service Licenses Francis Address Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complications are complicated to the complete shock of the complete ns that caused the death. use on each light. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Physician/Medical Completed by Be ၉ Certification:

Examiner law requires that the death certificate be executed burial-tran physician and Division or Vital Records, P.O. Box 68760, the ass attending use page 2 should has To the Hospital or Attending Physician: filled in by the funeral To the Funeral

Funeral

Director

Show

f Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f sho: other traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

If item 27 I

Department of F Important: If ite any Injury or ott

Physician

/Medical

Baltimore, Maryland 21215-0036

death with the Maryland

Cause (Disease or injury that initiated events resulting in death) Last	c								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pregnancy 1								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown									
		24a. Was an autopsy performed? 1 Yes 2 1 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 1 Yes 2 1 Yes							
25. Was case referred to medical	26. Place of Death	26. Place of Death (Check only one)							
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury Work? 1 Yes 2 No	d. Describe how injury occurred							
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	ff. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one)	nysician: To the best of my knowledge, death occurred at the time, date and place, an inner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)							

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

10+1

Medical

State

29b. Signature and title

31. Date filed (Month, D)

06

2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#29D Per HHY. State of Maryland / Department of Health and Mental Hygiene State Registrar 6/4/07 AACO HEALTH DEPT. CMH

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year June 2007 1:10P Dorothy S. Lehmkuhl 1. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ginger Cove Health Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Voar 1 M 2 XF Yrs 135-18-4902 Director 86 Dec.21,1920 New Jersey Usual Residence of Decedent or 28a-f show a notified at 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 📉 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or Items 23a or Medical Examiner must be r 4000 River Crescent Drive 21401 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: <u></u> Specify: White 3 ♥ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) the Chemistry Teacher Education s 1 and 2 should be filed v f Health and Mental Hygie ftem 27 is marked other t other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William H. Schroeder Matilda Granat 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: if Item 27 is y or other trai David W. Lehmkuhl/Son 1331 Grand Street, Apt. 604, Hoboken, New Jersey 07030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 Burial 2 □ Cremation 3 □ Removal from State Department o important: if any injury or once, Restland Mem.Park 6/9/2007 East Hanover,New Jersey 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Icens 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Solder the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** Condiomyopathy schemic disease or condition resulting in death) 19cms /Medical Due to (or as a consequence of): diovascular Disease **Examiner** pertensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine death certificate be executed ementia attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 DEctopic pregnancy 4☐Pregnant at time of death Month Year 5 ☐ Other (specify) signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? certificate has b 24a. Was an autopsy perform 1 ☐ Yes 1☐ Yes 2 No 2□ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 2 ER/Outpatient 3 DOA 1 Inpatient this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury spital or Attendir hours after death. Ineral Director: Aly filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6/2/07 29c. License number D20108 Mona 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rakesh Arora, MD 14300 Gallant Fox Lane Bowie, Maryland 31. Date filed (Month, Day, Year) 32. Refistrar's Signature

DHMH 17 Rev 1/2001

State

Registra

JUN 0 4 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Month **Physician** 3.05 PM Norman Henry Luzier MAY 31 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clen BURNIE ANNE ARUMBA の大きていると MEDICHE GRITECE If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 12/9/1936 Days M 2□ F 70 Maryland 213-34-9484 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State If item 27 is marked other than "natural", or items 23a or 28a-f show a other traumatic event, the Medical Examiner must be notified at 1 □Yes 2√□No Anne Arundel Severn Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21144 USA 7944 Telegraph Rd. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 No 1960-If Yes, Give Year or Dates: 1962 1 Never Married 23 Married 1 ☐ Yes 2€XNo White Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Maintenance 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paces 1 and 2 should be Madalen Melling Raymond Newton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Severn, MD 21144 Wife 7944 Telegraph Rd. Betty Luzier permit. Paces 1 and Departmen of Healt Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Glen Haven Cemetery 6/5/2007 Glen Burnie, MD 21. Signature of F all Service License 22. Name and Address of Facility Hardesty Funeral Home, P.A. Jal 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METASTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Dav Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 TYes 2∏ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2 s autopsy performe 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 ☐ Homicide 24 hours a Hospital completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar DHMH 17 Rev 1/2001

State

within 2 To the

29b. Signature)an

30. Name and ad

IN ABAN

31. Date filed (Month, Day, Year)

itle of certifie

JUN 0 4 2007

SOM.

pital

tress of person who completed cause of death (Item 23a) (Type, Prin

HOC

Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year 2 2007 Marie P. McIntyre June 4:30 PM M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Wicomico Nursing Home Salisbury Wicomico | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | N 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 X F 86 MD 212-18-6963 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No Hebron MD Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 209 W. Church St., Apt. 19 21830 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 █No Specify Specify 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Healthcare Attendant Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Daniel Perry Daisy Perry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7953 Belle Avenue, Hebron, MD 21830 Martha Dixon/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Acres Mem Pk 6/8/2007 Salisbury, MD 21. Signature of Funeral Service Lieunsee 22. Name and Address of Facility Lewis N. Watson Funeral Home ausor 1618 West Rd., Salisbury, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ARDIDMYOPATH Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) YLERTENSION Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1☐Yes ☐No Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Donknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 2 🔽 26. Place of Death (Check only one) 1 Yes Ve No Hospital: Other: Sursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury

Physician /Medical Examiner certificate be execute burial-tran and

attending physician

the detached

been signed by

has

certificate

this

After 1

To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

completely filled in by the funeral

the as use

for

Physician

/Medical

Examiner

Funeral

Director

show

r 28a-f

Items 23a or

10

and Mental Hygiene.

permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trau

1 and 2 should

altimore, Maryland 21215-00

Box 68760.

P.0.

Division or Vital Records,

Physician:

notified at

the Medical Examiner must be

Director

Funeral

þ

Completed

Examiner Completed page 2 s

Be

2

Certification:

Medical

Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

5 ☐ Pending investigation

6 Could not be determined

28b. Time of (Month, Day Year)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

31. Date filed (Month, Day, Year)

Natural

2 Accident

4 ☐ Homicide

3 ☐ Suicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

0063199

D

30. Name and ad ess of person who completed cause of death (Item 23a) (Type, Print)

Yogesh Vohra M.D. 614 Easternshore Dr Salisbury MD 21804

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

JUN 07 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Moore June 3, 2007 10:27 Ann /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City. Town, or Location of Death **Examiner** ROGIONOT Salister MINSILA Mamico If Under 1 Year | If Under 24 Hrs 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 ☐ M 2 🕱 F Months Hours 214-80-4492 39 6/19/1967 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits 1 Yes 2 No Directo Maryland Wicomico Salisbury 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 569 West Road, Apt. 102 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ò white 3 Widowed 4 Divorced Completed Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Georgie Powell Arlene Gordy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Ann Davis/daughter 569 West Rd., Apt. 102, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Xemation 3 ☐ Removal from State 6/5/07 Salisbury Crematory Salisbury, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Holloway Funeral Home Professional Association 21. Signature of Funeral Service Licer 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DRAINSTEM EMORRIHAGE disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to infine diet cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If ves, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 mg Month Year Day 4□Pregnant at time of death 9□Unknown 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a. Was an autopsy 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

burial-transi 68760 pe Division or Vital Records, P.O.

attending physician and for use as the burial-tran signed by the at d be detached for Hospital or Attending Ph 4 hours after death. Funeral Director: After th tely filled in by the funeral

Funeral

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

2 Be 2 Medical

To the	within 2	To the I	complet
1	X	00	2

State Registrar 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

M. IHIMMAR 6/4

31. Date filed (Month, Day, JUN 06 32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year June 6, 2007 4:05 PMLaris Virginia Maxwell 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Gilchrist Hospice Baltimore Towson If Under 1 Year 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Months Hours Min Year 921 West Virginia 1 □ M 2 🕟 F 86 12 Jan. 235 20 6048 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Howard Ellicott City 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 8541 High Ridge Rd 21043 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Cox Ava Mini 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra J. Brownfield/daughter 757 Roddenberry Ave. Las Vegas, NV 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory 6/7/2007 Catonsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. M01442 4112 Old Columbia Pk. Ellicott City, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) nonths NNG Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) WOSFIW 1 🔲 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

permit. Page Department o Important: If any Injury or

Physician

/Medical

Examiner

Funeral Director

Completed by

Be

မ

iner

Exam

Physician/Medical

2

Completed

Be

P

Certification:

Medical

MD

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

and burial-trar physician the anding F as nse atter signed by the a d be detached f has le 2 s , page certificate After this certific funeral director,

requires that the death certificate be executed

Box 68760,

o

٦

Division or Vital Records,

or Attending

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

examiner? 1 ☐ Yes 2 No 27. Manner of Death

5 Pending investigation

28a. Date of Injury (Month, Day Year) 6 ☐ Could not be

2007

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28d. Describe how injury occurred

Charles St Bowson MD 21204

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 🗖 Natural

2 Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at Work?

29b. Signature and title of certifier, 30. Name and address of person who completed cause of death (Jtem 23a) (Type, Print)

JUN 0

29c. License number

29d. Date signed (Month, Day, Year)

22 State

within 24 hours after occ..

To the Funeral Director: Aft

31. Date filed (Month, Day, Year)

CHAVES w 6701 Posistrar's Signature

Registrar

			For State Registrar	State of	Maryland		rtment e			and Mer	ntal Hy	/giene Reg. No.	0/10	7	
			Hegistrar Decedent's Name (First, Middle)	, Last)						2.	Date of D	eath	1.70 10 10	3. Tin	ne of Death
	Physici /Medic		CAROLYN V	ANETTA MILI	LER					JT	Month JNE	04	2007	8:	35 A ^M
	Examin		4a. Facility Name (If not institution	, give street and numb	er)		4b. City, To	wn, or Lo	ocation o	of Death		4c.	County of Dea		
			UPPER CHESAPEAK				If Under 1		L AI		Date of Ri	irth	HARF		ate or Foreign
	Funeral		5. Social Security Number	6. Sex 7.	. Age (In yrs. la 37	Yrs.			Hours	Min.	(Month, D	irth lay, Yea <i>r</i>) 197	1 0	ountry) RYLAN	D
	Director		218-94-8812 Usual Residence of Decedent									, , , , ,			
	ylanc now		10a. State 10b. County		10c. City	, Town or Lo	cation								de City Limits Yes 2 ☐ No
	e Mal	ᅙ	MARYLAND H	ARFORD			HAVR		GRA	CE					Tes ZINO
	3a or 24	al Dire	10e. Street and Number 4203 WEBSTER	LAPIDUM RO	OAD		10f. Zip C		078			10g. Citi:	zen of What C USA	-	
))36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show may injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marr 3 □ Widowed 4 □ Divorced	12. Was Decedon Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date	es? XNo	'	Was Deceder If Yes, specifi 1 ☐ Yes 2	y Cuban,	oanic Ori Mexicar Specify:	gin? (Specify n, Puerto Rica	Yes or N an, etc.)	lo-	14. Race - Am Black, Wh Specify: B	ite, etc.	n,
5-0	"natura	eted	15. Deceden (Specify only highe	t's Education st grade completed)		(Give	dent's Usual kind of work DO NOT use	done dui	ion ring mos	t of working		16b. Ki	6b. Kind of Business/Industry		
35	d within giene. rr than the Me	Completed	Elementary/Secondary (0-12)	College (1-4	lor 5+)		HEAD T		IR				BANKIN	iG	
Son	be file ntal Hy ed othe event,	Be	17. Father's Name (First, Middle, ROBERT STANDIF		CMTTH			'		er's Name <i>(Fi</i>)L ANN			Surname)		
C ryle	hould of Men marke matic	2	19a, Informant's Name/Relations		SMITTI	19b. Mailir	ng Address (r Town, State,	Zip Code)	
7 Mary	nd 2 s lith an 27 is r trau		KEVIN MILLER /			4203	WEBST	ER L	APII	DUM ROZ	AD, H	IAVRE	DE GRA	CE, M	D 21078
	is 1 and 2 of Health Item 27 other tr		20a. Method of Disposition			lace of Dispo	sition (Name	of er place)		Date)	20c. Lo	ecation - City of	r Town, Sta	te
700	Page nent c int: If		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		B E	ERKLEY	CEME	I'ERY		6/9/0	7	DAR	LINGTO	N, MAI	RYLAND
Balt	permit. Departr Importa any inj		21. Signature of Funeral Service	Licensee	ener	22	LISA 552 L	SCOT	म मा	NERAL	HOME HAVRE	E, P.A	A. GRACE,	MARYL	AD 21078
305) S	Cate be executed physician and physician and the burial-transit	dical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, issuing to increase cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a	r as a consequence as a	uence of):	. bi	(eu	-5+	Ca	nc	eV		Interva Onset	kimate all Between and Death Mun Th
30029C	w requires that the death certificate been signed by the attending physishould be detached for use as the	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Feta ınt at time of d	Ideath 3	⊒Ectopic pre ⊒ Other <i>(spe</i>						23d. Date of d Month	elivery Day	Year
M S	requires that sen signed by	d by Pr	Part II. Other significant conditi	ons contributing to dea	ath but not res	ulting in the u	inderlying cai	use giver	n in Part I	l.			use contribute ☑No 3□		e of death?
rolyn M	The la ate has page 2	Complete									24a. Wa au pe 1∐ Yes	topsy rformed?	prior t death	o completio	dings available n of cause of
\ ₹	ysiclan: is certific director,	Be	25. Was case referred to medical examiner?	Hospital:				Other	,.	e of Death (_		
75	di is	2	1 Yes 2 No 27. Many of Death	28a. Date o		ER/Outpatie		`	4 🗆 🖂				6 □Other (Single of the first occurred)	pecify)	
Miller C	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 4 Homicide Accident 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work?										e Number,		
$\sum_{i=1}^{n}$	Hospital 24 hours a Funeral stely filled	Jical C	29a. Certifier 1 Certifyi (Check only one) 1 Medica	ng Physician: To the last Examiner: On the ba	sis of examina	owledge, dea ation and/or i	th occurred a nvestigation,	at the time in my op	e, date a inion, de	and place, and eath occurred	d due to the at the time	ne cause(s ne, date an	s) and manner ad place, and c	as stated. lue to the ca	ause(s)
	To the within 2	Med	29b. Signature and title of certific	1	mn		I	License	18	41		4	ate signed (Mo	7	
	7		30. Name and address of person ASh Kan B	ahrani f	of death (Iter	n 23a) (Type	Print)	NOC	df	2d.,5	te S	200	Beldir	mo	21014
	St Regist	ate rar	31. Date filed (Month, Day, Year JUN	6 2007	Legua.	H.	Sports	0							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year а м 2, 2007 June McCallum Donald Nicholson 10:11 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring If Under 1 Year | If Under 24 Hrs 9. Birthplace (Star Country) <u>720 Hillsboro Drive</u> 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday Social Security Number Months Davs Hours 1 M 2 □ F 29, Oct. 1937 Scotland 296-46-8438 69 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Hillsboro Drive 20902 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces I ☐ Yes 2 ☑ No f Yes, Give 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 No 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Naval Architect Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Donald Nicholson McCallum Amelia McKenzie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lise P. McCallum/ Wife 720 Hillsboro Drive, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State June 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery 4 Donation 5 Other (Specify) 2007 Silver Spring, Maryland 21. Signature of Funeral Service Licenses Francis Address Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final Metastatic Non-Small Cell Lung Cancer l year disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Errer Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🔀 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

or 28a-f

permit. Pages 1 and 2 should be filed within 72 hours after death with i Department of Health and Mental Hygiene. I important: If them 27 is marked other than "natural", or Items 23a or 3 any Injury or other traumatic event, the Medical Evantian manage.

Baltimore, Maryland 21215-0036

the

Examiner must be notified at

Director

Funeral

þ

Completed

Be ၉

Examiner Physician/Medical δ Completed Be မ Certification:

il or Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760

IF FEMALE 23b. Was decedent pregnant 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an

24b. Were autopsy findings available prior to completion of cause of

autopsy performe 2**6** No death? 2 No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home SEResidence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28h. Time of 28d. Describe how injury occurred

27. Manner of Death 5 ☐ Pending investigation 1X Natural 2 Accident 6 ☐ Could not be 3 ☐ Suicide

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 ☐ Homicide

29a. Certifier

****Yertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier,

D52767

29d. Date signed (Month. Dav. Year) June 6, 2007

30. Name and address of person with completed cause of death (Item 23a) (Type, Print)

Harminder Sethi, M.D.

1400 Forest Glen Road, Suite 435, Silver Spring, MD 20910

State Registrar

filled

5

Medical

31. Date filed (Month, Day, Year) 2007 06 JUN

determined



Hospital To the Hospital within 24 hours a To the Funeral C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** onth jano 0322 AM arina 200 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death Shady Grove Adventist Rockville Montgomery. 7. Age (In yrs. last birthday) 53 Yrs. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Hours Months M977-89-1954 1 ☐ M 2 🔀 F EI Salvador 578-90-7932 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at MD Montgomery Gaithersburg 1 □Yes 2X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 746 Clopper Road #13 20878 USA Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 à Specify. White 3 Widowed 4 Divorced El Salvadoren Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self employed Hairdresser permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked othe any injury or other traument. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernardo Majano Evangelina Cruz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 746 Clopper Road #13 Gaithersburg, Md20878 Jose Sandoval/Son 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Delisias de 1 XBurial 2 □ Cremation 3 XR proval from State 6/11/2007 Morazon, El Salvador 4 Donation 5 Other (Specify Concepcion 21. Signature of June al Service PHILIPADESRINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** a Atheroscherotic Cardiovascular Diseuse MONTH disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner months liabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner months ng physician and as the burial-transit Hypertension The law requires that the death certificate be executed Due to (or as a consequence of) ed by the attending physician detached for use as the burial Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 25 No 9 Unknown 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 hknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy pertormed' 1 Yes 2 D Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred after death. Certification: 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

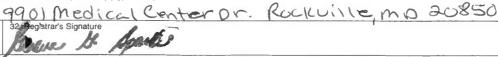
∞ State Registrar

31. Date filed (Month, Day, Year)

JUN 0 6 2007

Delarch Sherrinmo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Registrar

State

Road S.

Capital Heights

Addison

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

1458

Debra A. Vereen

JUN 0 7 2007

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

					Oldio c	, ,,,,	i yidiid / i		ificate				ionai ri	Reg. N	LU	UI	15	933
		1. Decedent's Nam	ne (First, Midd	lle, Last)	_							2. Date of D	eath		Vee	3. Time o	of Death
Physic /Medi		DOLORES	A. MA	RTI	N.								Month JUN€	- 3	ay -2	Year	815	AM
Exami		4a. Facility Name ('If not institution	on, give	street and nu	mber)				4	b. City, To	own, or Lo	ocetion of Dea	th 4	c. County	of Death		
		ST. THO	MAS MO	RE 1	NURSIN	G AN	D REHA	В			H	YATTS	VILLE		PRIN	CE G	EORGE	S
Funeral		5. Social Security N		6. Se	х ⊐м Х2Х Эг	7. Age	(In yrs. last bii		If Under 1	Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D	irth <i>ay, Y</i> ea <i>i</i>	r)	9. Birthp Coun	lace (State try)	or Foreign
Director		577 34			J 10(2)226_J 1		78	Yrs.					MAY 14	, 19	929	WASI	HÍNGT	ON, DC
and w		Usual Residence of 10a. State	10b. Count	v			10c. City, Tow	n or Loca	ation							1	Od. Inside (City Limits
the Marylar 28e-f ehow	ō	MD	DDTNC	re Ci	EORGES		FORT			NT							χħ,⊡ Yes	
the 1	Director	10e. Street and Nu	1	L G	LORGED		TORT	WIIDII	10f. Zip Co					10a C	itizen of V	Vhat Coun	trv?	
Sa or		1736 RF	IODECTA	. A 37 1	CMIIC				110	074	/.			-		STA'		
death ms 2	Funeral	1730 KI	IODESTA		12. Was Dec Armed Fo	edent Ev	er in U,S.	13. W				igin? (Sp	ecify Yes or N Rican, etc.)		14. Race	e - Americ	an Indian,	
or ite		1 ☐ Never Marr	ried XX Ma	rried	Armed Fo 1 ☐ Yes If Yes, Gir	rces?							Rican, etc.)			k, White,	_	
ours a	þ	3 D Widowed	4 Divorce	d	If Yes, Gr Year or D	ve ates:		11	□Yes XX	₫ No	Specify:				Specify	BLA	CK	
should be filed within 72 hours after death with the Maryland nd Mental Hygiene. In marked other then "netural", or items 23a or 28e-f ehow umatic event, the Maddal Exaninal must be notified a	Completed	(Spec	15. Deceder	nt's Edu	cation e completed)		16e.	Decede	ent's Usual C	Occupa done d	ation during mos	st of work	ina	16b. I	Kind of Bu	siness/Inc	lustry	
e e .	훁	Elementary/Seco			College (1-4or 5+			ind of work of O NOT use i					_				
led w lygier her tt	S	12TH	(Fine 14:14)					PRO	GRAM A	ANA							OVERN	MENT
be fi	Be	17. Father's Name		2.5									e (First, Middle	e, Maide	n Surnam	θ)		
d Mer	2	ARTHUR					401	8.4 - 111	A				BROWN			a =		
d 2 sl th and 7 Is r traur	1	19a. Informant's N					11						al Route Numb FORT WA				•	<i>/</i> .
1 an Heal em 2		ALMEDA 20a. Method of Dis		21	STER		20b. Place of	f Disposi	RHODE tion (Name	of		•]	Date Date			City or To		+
permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "ne any injury or other traumatic event, the Macil once.		XX Burial 2	□Cremation		lemoval from	State			tory or othe		,	N .				•		
artme ortan	1.76	4 ☐ Donation			96		WASHIN						/11/07	5	ULTL	AND,	MD	
Depi Impo	Į. Į.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARSHALL'S FUNE AND ADDRESS OF FACILITY AND ADDRESS OF FACILITY 22. Name and Address of Facility AND ADDRESS OF FACILITY AND ADDRESS OF FACI																
		23a Parti Enert	4308 SUITLAND RO												D, MI	207		to.
Dhusisian		23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such es card shock, or heart failure. List only one cause on each line.												arrest,		1	Approxima Intervel Be Onset end	lween Death
Physician /Medical													\$4.	7	-	^		
Examiner		disease or condition resulting in death)	on	á	ave		ue to (or as e			21		اران	og me	112	0120	ns		
	Je					Di	16 (0) (0) as 6 (consequi	ence or):							1		
be executed sician and burial-transit	Examiner	Sequentially list co	nditions.)	Di	ue to (or as e o	conseque	ence of):									
e exe ian a urial-t	Ĕ	Sequentially list co if any, leading to in ceuse. Enter Unde Cause (Disease or that initieted events	nmediate erlying	J														
ee % ee	edical	that initieted events resulting in death)	injury S Lest	S '		Du	e to (or es e c	onseque	ence of):							+		
entifice ding pl	¥e.	•		L.												1		
eath cer attendin I for use	lan																	
at the de by the a stached f	Physician/	Part II. Other eignif					_			_			23b. Did	tobecc	o use con	tribute to	the ceuse	of death?
that the		Arter	rosul	en	0652	Ca	rdie	Va.	sala	r	101	rea	1 1	Yee 2	2□ No	3 Prob	ably 4⊡	Unknown
ires that signed b	d by	0											24a. Was			24h Wa	re autopsy	findings
w require been sig	ete	Cena	كامع	('	Ky Lo	mb	54 ZU						perf	ormed?	ppay	con	ilable prior pletion of (to
The law ete has page 2 s	Completed	1	1- 0X	00	Me	(1 no	1.0										eeth?	
icien: The certificete irector, pag		os Warner	201		v. Ce.	10	12								No	1 🗆	Yes 2□	No
Physicien: r this certifice aral director, p	o Be	25. Was case reference exeminer? 1 ☐ Yes 2 ☐			ospital:		о П гр.ю	44*4	o□ D04	Othe			(Check only		a [] au	6 1		
Phys r this eral d	7: To	27. Menner of Deat			28a. Date	npatient of Injury	2 □ ER/Ou 28b. T	ime of	3□ DOA 28c.	Injury Work			me 5 🗆 Resi 28d. Describe)	
ding th. : Afte e fune	ţ	1 ☑ Natural 2 ☐ Accident	5 Pendir investi		(Mont	h, Day Y		njury	м		:? /es 2 ☐ I	No		·	•			
Atter r dea ector by the	II CS	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could determ	not be	28e. Place	of Injury	- At home, fa	rm, stree	it, factory, of	ffice		- 2	28f. Location (Street a	nd Numbe	er or Rural	Route Nun	nber,
s afte	Certification:	4 LI Homicide			buildii	ng, etc. (Specify)						City or To	wn, State	θ)			
To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificete has E completely filled in by the funeral director, page 2 s	edical (29a. Certifier (Check only	1 Certifyin	ng Phys	iclen: To the	best of r	ny knowledge emination end	, death o	ccurred at the	he time	e, date an	d place, a	and due to the	cause(s	and mar	nner es sta	ited.	-1
the H in 24 the Fi		one)			and manr	ner state	d.	J/OI IIIV O :	sugation, in	пу ор	iiiioii, dea	in occurre	ed at the time,	date an	o piace, a	na aue to	the causet	")
To To T	Σ	29b. Signature and	title of certifie	111	11.	1			29c. Li	icense	number	~		29d. Da	ate signed	(Month, E	ay, Year)	
25			hour	Un	Uli	1/2			0	0,	15) d	^	VIA	10 3	,20	07	
142		30. Home and address	F, D	who co	Oleted caus	e of deal	th (Item 23a) (Type, Pr	int) VER	NS	bure	1 Ra	1 Hy	atts	30:11	4 p	D2	0781
Sta Registr		31. Date filed (Monit	th, Day, Year)	7	32. R	egistrer's	Signature	de			/		·l					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

			1 - For State Registrar	State of Marylar			nt of He te of C		nd Me		iene eg. No.		7	19940
<i>y</i> ,	Physici	an	1. Decedent's Name (First, Middle, Las	")						Date of Deat Month	h Day	,	Year	3. Time of Death
	/Medic			E. MCNEIL		1				JUNE	2	2007		11:35 P M
9	Examir	er	4a. Facility Name (If not institution, give				, Town, or I	_ocation of	Death			County of		_
100	5)	243 -	PRINCE GEORGE S 5. Social Security Number 6. Se		last hirthday)		VERLY or 1 Year	If Under 2	4 Hrs.	8. Date of Birth				ORGE S
100	Funeral Director			□M 2XF 81	Yrs.	Months		Hours	Min.	(Month, Day,	Year)		Con	GINIA
	ס		Usual Residence of Decedent							IMICH O	172			
	irylan show	_	10a. State 10b. County	10c. Ci	ty, Town or La	ocation								10d. Inside City Limits
	Ba-f	Director	MD PRINCE (GEORGE'S LA	NDOVER									1 Yes 2 No
	with th	급	10e. Street and Number	A 3.777		10f. Z	p Code	00705		1	_	en of Wh	nat Cou	intry?
	within 72 hours after death with the Maryland ene. then "natural", or Items 23s or 28s-f ehow he Madical Examiner must be notified at	Funeral	7405 GRAYRIDGE I	ANE 12. Was Decedent Ever in U	10 13 1	Was Dec		20785		ofy Ves or No-		A Bace	- Amer	ican Indian,
	her d	F	11. Marital Status 1 Never Married 2 Married	Armed Forces?		f Yes, sp	ecify Cuban	, Mexican,	Puerto F	cify Yes or No- lican, etc.)	'		White	
036	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗌 Yes	2 X No	Specify:			,	Specify:	BLA	CK
Maryland 21215-0036	72 ho	Completed	15. Decedent's Ed (Specify only highest grad	ucation			ual Occupat		of workin	la la	16b. Kin	d of Bus	iness/li	ndustry
2	ithin Mar	oldu.	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	use retired)	ning moot		9				
2	filed w Hygier other th		11TH 17. Father's Name (First, Middle, Last)		DOM	ESTI		10 Mathar	de Momo	(First, Middle, I		RIVA		
anc	to pe	Be	JAMES E. TAYLOR					ELE		CLOGGIN		sumame,	,	
٦	should ind Men marke	2	19a. Informant's Name/Relationship (7	voe. Print)	19b. Mailir	na Addres	s (Street ar			Route Number		Town, S	tate. Zi	c Code)
<u>8</u>	Ith ar Ith ar 27 le		CORNELIUS MCNEII			_				NDOVER,	-			
Baltimore,	Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. ant: If Item 27 te marked other then "natural; or Items 23a or 28a-1 show try or other traumatic event, the Madical Examiner must be notified at ury or other traumatic event, the Madical Examiner must be notified at		20a. Method of Disposition		Place of Dispo cemetery, crer	osition (Na	ime of) I	Da	ate	20c. Loc	ation - C	ity or T	own, State
Ë	Page nent o nt: If		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	RYLAND	- 1		1	/9/2	007	LAUR	EL,N	ARY	LAND
aĦ	permit. Page Department of Important: If eny injury or once.		21. Signature of -unit ry Service Coens	See /	22	2. Name a	nd Address	of Facility	J.	B. JEN				
<u> </u>	80E 5 8		MONOYYE	NDen	OK)	7474	LAND	OVER	ROAD	LANDOV	ER,M	ARYI	AND	20785
	Physician /Medical Examiner	<u>.</u>	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions	ilications that caused the deal one cause on each line. I SCHEMIC Consumer and the consume	HOLECY		de of dying	, such as c	cardiac or	respiratory arro	est, 			Approximate Interval Between Onset and Death
	ted nsit	nlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	CORONARY A		DISE	ASE							
	cate be executed bhysician and the burial-transit	Examiner	that initiated events 'resulting in death) Last	c. Due to (or as a consec									-	
8760	s be (sicial)	dical		d.										
Box 6	ath certifications in the second of the seco	by Physician/Medi	in the past 12 months?	23c. If yes, outcome of pregn 1 Live birth 2 Fetr 4 Pregnant at time of 6	aldeath 3□	⊒Ectopic ¡ ⊒ Other (s	oregnancy				2	3d. Date Monti		rery Day Year
P. O.	res that the de signed by the a be detached f	Phy	9 Unknown							00 0111	[(1,10
	w requires the been signed should be d	ed by	Part II. Other significant conditions co	entributing to death but not re-	suiting in the u	nderlying	cause giver	n in Part I.				No 3		the cause of death? bably 4 Aunknown
Records,	The law rate has be	Completed								24a. Was a autops perform	V	de	ere aut or to co ath? Yes	opsy findings available ompletion of cause of
Vital	rtifica	Be C	25. Was case referred to medical					26. Place	of Death	(Check only on				24.140
>	ysic direc	ToE	examiner? 1 ☐ Yes 2 ☐XNo	Hospital: 1 🔀 Inpatient 2 🗆	ER/Outpatier	nt 3 🗆 🗆	OA Other	. 4 🗆 Nur	sing Horr	ne 5 🗆 Reside	nce 6	Other	(Spec	ity)
0	ng Pl		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f	28c. Injury Work	at ?		8d. Describe ho				
Division of	Attending Physician: r death. sctor: After this certific: by the funeral director.	catl	2 Accident investigation 3 Suicide 6 Could not be			М		es 2□N						
\leq	l or At after d Direct I in by	Certification;	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str fy)	reet, facto	ry, office		2	Bf. Location (St City or Town	reet and n, State)	Number	r or Rui	al Route Number,
_	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page		29a. Certifier 1 X Certifying Phy	rsician: To the best of my kn	owledge death	h occurre	d at the time	a. date and	i place a	nd due to the o	ausale)	and man	nar as	stated
	e Hos 24 h Fun e Fun	Medical	(Check only 2 Medical Exam	iner: On the basis of examination and manner stated.	ation and/or in	vestigatio	n, in my opi	nion, deati	h occurre	d at the time, d	ate and	place, ar	d due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29	c. License		_				·	, Day, Year)
)			I)5818	2		JUNE	6 2	:007	
L	10		30. Name and a ress of person who d	ompleted cause of death (Ite	т 23а) (Туре,	Print)								
	(0)		C. DONALD GEORGE			E CHI	EVERLY	,MAR	YLAN	D 20875				
	Sta Registi		31. Date filed (Month, Day Year)	32. Registrar's Sign	all.									

		For State Registrar		State of I	Marylan		artmen <i>rtificat</i>		ealth and N Death	Mental Hy	/giene Reg. No.		1	
Dhyaial		1. Decedent's Nam	e (First, Middle, La	st)						2. Date of D Month		Yea		3. Time of Death
Physicia /Medic		Elizabe	th Barnet	t McClel	1and					May	21	200	7	8:53a M
Examin	er		If not institution, giv					_	Location of Death			County of De		
		5. Social Security N	ery Gener	_		last birthday)		Olney	If Under 24 Hrs.	8. Date of B		ontgon		e (State or Foreign
Funeral Director		484-09-8	1	□M 2 ⊠ F		89 Yrs.	Months	Days	Hours Min.	Jan. 3	ay, Year)		Country)	e (blate of Foreign
		Usual Residence of	Decedent							Joan.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	710 1		
arylar show d at	_	10a. State	10b. County			ty, Town or Lo								Inside City Limits 1 ☐ Yes 2 K No
he M 28a-f	ecto	Maryland 10e. Street and Nu	Montgo	mery		Rockvi		0.1			40022			
with t	i		mber iley Driv	· A			10f. Zip	0850			_	zen of What ted St		
ms 23	Funeral Directo	11. Marital Status	iio, biiv	12. Was Decede	ent Ever in U	l.S. 13.			spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or N		14. Race - Ar		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M-dical Examiner must be notified at once.	þ		ried 2 ☐ Married	Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date	⊠ No	1	If Yes, spe 1 ☐ Yes		n, Mexican, Puerto Specify:	o Rićan, etc.)		Black, W Specify:	hite, etc. Whit	te
72 ho natur lical E	Completed	(Spec	15. Decedent's Ed	ducation		16a. Dece	dent's Usua	al Occupa	ation during most of work	kina	16b. Kii	nd of Busines	ss/Indust	try
ithin 7 e. nan "i	nple.	Elementary/Seco		College (1-4	or 5+)	life.	DO NOT us	se retired)	King				
led w lygier her th	S	17 Fathada Nama	(Final Mindella Lank			I	Homema	aker	40 Bloke de Nore	- /Final 881441		wn Hon	ne	
d be findal Hed of ed of eed of ever	Be	Glen B	(First, Middle, Last,	,					18. Mother's Nam			Surname)		
should nd Me mark matic	은		ame/Relationship (Type, Print)		19b. Maili	na Address	(Street a	and Number or Ru			r Town. State	a. Zip Co	de)
nd 2 salth ar 27 is r trau			cClelland		r	1			Orive, Ro					30)
s 1 a		20a. Method of Dis		1		Place of Dispo cemetery, cre	osition (Nar	ne of other plac	e)	Date	20c. Lo	cation - City	or Town,	, State
Page ment c									fory 5/29	9/07	Bren	twood,	, Mai	ryland
permit. Departimporti		21. Signature of Fu	uneral Service Licel	see		1	Simple	e Tri	ss of Facility ibute Fur ville Pik				on Ce 208	
1000		23a. Pax1. Enter t	the disease, ir or m art failure. List nly	plications that cau	sed the deat							0, 110	Ap	proximate terval Between
Physician		Immediate Cause disease or condition	(Final	Demen									Or	nset and Death Years
/Medical Examiner		resulting in death)		Due to (or	as a consec	quence of):								·
Examiner	Ļ	Sequentially list co	onditions,	b										
ted nsit	Examiner	cause. Enter Unde	erlying	Due to (or	as a consec	quence or):								
al-tra	Xar	that initiated events resulting in death)	S	c Due to (or	as a consec	quence of):							+	
e be	edical			_d										
rtificat ng phy as th									-					
ath ce tendir or use	Physician/M	IF FEMALE: 23b. Was deceden in the past 12		23c. If yes, outcome 1□Live birth			⊒Ectopic pi	regnancy			2	23d. Date of		Vana
the all	/sici	1 ☐ Yes 2 ☐ 9 ☐ Unknown	□No	4□Pregnan 9□Unknow		death 5	Other (sp	ecify)				Month	Da	y Year
that the set by detac			ficant conditions	contributing to deat	h but not res	sulting in the u	ınderlvina c	ause give	en in Part I.	23e. Did	tobacco u	se contribute	a to the c	ause of death?
signe d be	d by	Osteopor		g		g	,g -	g			_	_		y 4 ∐Unknown
w req	Completed	Osteoart	hritis							24a. Wa	s an	24h Were	autonsv	findings available
The lassage 2	ᇤ							_		aut per	opsy formed?	prior death	to compl 1?	etion of cause of
an: rtifical tor, p	a l	Hyperlip 25. Was case refer							26. Place of Dea	th (Check only		1 U Y	es 2	
nysicl nis cen direc	O B	examiner? 1 ☐ Yes 2 🎇	No	Hospital: 1 ☐ Inp	atient 2	ER/Outpatie	nt 3 DC	Othe				6 □Other (S	pecify)	
ng Pł	J:UC	27. Manner of Dea	th 5 Pending	28a. Date of (Month,	Injury Day Year)	28b. Time o	of 2	28c. Injun Work	y at	28d. Describe	how injur	y occurred		
tendi eath. tor: A the fu	Certification:	2 ☐ Accident	investigation 6 ☐ Could not b				М	1 🗆 '	Yes 2 □ No					
or At ifter d Direct in by	ij	4 ☐ Homicide	determined	28e. Place of	injury - At h , etc. <i>(Speci</i>	ome, farm, st fy)	reet, factory	y, office		28f. Location City or To	(Street an own, State		Rural R	oute Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death. Within 42 hours after death. To the Funerial after death. Completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier	1€ Certifying Ph	nysician: To the be	est of mv kni	owledge, dea	th occurred	at the tin	ne, date and place	and due to th	e cause(s)	and manner	ac ctata	nd
e Hos 24 hd e Fun letely	Medical	(Check only one)	2 Medical Exa	miner: On the basi and manner	is of examina	ation and/or in	nvestigation	i, in my o	pinion, death occu	rred at the time	e, date and	I place, and	due to the	e cause(s)
within To th	Me	29b. Signature	title of certifie	· 1 25	\		290	c. License	e number		29d. Dat	e signed (Mo	onth, Day	v, Year)
10) [C	put p	N M	A			D347	40		J	une 4,	200)7
10			ress of person who											
		Robert Fi					ip Dr	., S	uite 200	, Olney	, Mar	yland	208	32
Sta Registr		31. Date filed (Mor	IN 0 5 20)07 32 leg	istrar's Sign	sture	anti)							

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 6/2/07 **Physician** 4:50 рм S. Maas Ernst /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Lutheran Home National If Under 1 Year | If Under 24 Hrs. | 8. Date of 8 irth Months | Days | Hours | Min. | 3 (Month Days 25) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 82 yrs 5. Social Security Number 6 Sex **Funeral** Germany 1**™** M 2□ F Yrs. 456-24-4168 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County a 23a or 28a-f show Potomac Md. Montgomery 1X Yes 2 No Direct 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number US 20854 2416 Stratton Drive Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. the Medical Examiner I⊠Yes 2□NdWII White 1 ☐ Never Married 2 X Married ö 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "naturel" ieted 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) 5+ Compi Elementary/Secondary (0-12) US Government Economist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental P Pages 1 and 2 should be inent of Health and Mental I ant: If Item 27 Is marked o Erna Levy alter Maas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Maas-Wife 2416 Stratton Drive Potomac, Md. 20854 Jeanette Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State King David Memorial permit. Page Department of Important: If any Injury or once. 6/4/07 Falls Church, Va. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Danzansky-Goldber Danzansky-Goldberg 1170 Rockville Pike Rockville, Md. 20852 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode/ f dying, such as cardiac or respiratory arrest shock, or heart failure. List only one caus in each link. Approximate Interval Between On et ind De th Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (as a consequence of): Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the indertying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 🗌 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27 Manner of Death Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier License number Clives 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, Md. 20850 9701 Veirs Dr. Charles W. Karesh 32. Agistrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 5 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Joseph I. McGovern May 31, 2007 8:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 3629 Gleneagles Drive Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1⊠M 2□F Yrs. 025-24-6059 73 Director 19, 1934 Massachusetts Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3629 Gleneagles Drive, #3-1A 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1955 1 Never Married 2 Married 1 ☐ Yes 2 No SpecifWhite ρ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d other than "natu event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HHS Systems Analysis Government. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Paul McGovern Kathleen Hazel Delaney ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13704 Sherwood Forest Drive, Silver Spring, MD 20904 Andrew D. McGovern/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of H
Important: If ite
any Injury or of Gate of Heaven Cemetery June 5, Tx Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007_ Silver Spring, Maryland 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd, W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition Coronary Artery Disease resulting in death) /Medical Due to (or as a consequence of) Examiner Cardiomyopathy Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to [or as a consequence of]: Examine burial-transi Metastatic Liver Disease that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0036

After

Certification: To within 24 hours after death

To the Funeral Director:
completely filled in by the 29a. Certifier 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D43496 June 4, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

Mohammad Khalid, M.D.

2007

5 Pending investigation

6 Could not be determined

12001 Ferrara Drive, Wheaton, MD 20906

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

27. Manner of Death

1 √ Natural

2 Accident

3 Suicide

4 Homicide

31. Date filed (Month, Day, Year)

JUN 05



28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

			_ State	aryland / Dep			Mental Hyg	jiene		The State Control of
			Registrar 1. Decedent's Name (First Middle, Last)	Ce	rtificate of	Death		eg. No.		994
	Physic /Med		Noels. Mc pherson				2. Date of Dear	Day	Q Year	3. Time of Death
	Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County		15:37 4
			Montgomery General Hospit	al	Olne	V		Mc	ntgon	nerv
	Funeral		5. Social Security Number 6. Sex 7. Ac	e (In yrs. last birthday)	if Under 1 Year Months Days	If Under 24 Hrs. Hours Min,	8. Date of Birth (Month, Day,		9. Birthol	ace (State or Foreign
	Director		578-48-3974 Usual Residence of Decedent	83Yrs.	24,0	I TOGIO	March 2		Count	maica
	land ow		10a. State 10b. County	10c. City, Town or Lo	ocation		0.000			
	Mary fled a	ţ							110	0d. Inside City Limits
	r 28a	Director	Maryland Montgomery 10e. Street and Number	Roc	kville 10f. Zip Code			0 000		1 ☐ Yes 2 No
	h with	2	16402 Upbrooke Court		20853		"	0g. Citizen of USA	What Count	iry?
	deat	Funeral	11. Marital Status 12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hi	spanic Origin? (Sp	ecify Ves or No.		e - America	on Indian
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland Maryland Maryland Hygiene. The Matural", or Items 23a or 28a-f show marked other than "natural", or Items 23a or 28a-f show matte event, the Medical Examiner must be notified at	b	Armed Forces? 1 Never Married 2 Married 1 Pyes 2 1 3 Widowed 4 Divorced 1 Fyes, Give Year or Dates:	NO I	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2☐ No	Specify:	Rican, etc.)	Blac	ok, White, e	etc.
2-0	72 ho natur	Completed	15. Decedent's Education	16a. Dece	dent's Usual Occupa	ation	T- 9	16b. Kind of B		
21	thin 7 an "r	ed.	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Give	kind of work done d DO NOT use retired,	luring most of work)	ing	TOD. KING OF DI	usiness/ingi	ustry
2	ge wil	į	1		U.S. Mars	hall],			
p	be file	Be (17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, N	Law Enf Maiden Surnan	orcem	ent
<u>8</u>	should be filed nd Mental Hygi marked other Imatic event, I	2	Joshua McPherson			Roslvn	Abrahams	3		
lar	S 8 8 1		19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a				State, Zip (Code)
			Nenita W. McPherson/Wife		Upbrooke					,
9	ges 1 It of H If Itel		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, crer	sition (Name of matory or other place) T.	Date 2	20c. Location -	City or Tow	vn, State
Ë	nit. Pages partment of cortent: If Its injury or o		4 □ Donation 5 □ Other (Specify)	Gate of 1	Heaven Cer	meterv	ne 7, 2007 Si	ilwan C	~~.	,Maryland
Baltimore,	permit. Departimont any inj		21. Signature of Funeral Service Licensee	F	Name and Address	s of Easility ins	Funeral	Home T	pr rud	Maryland
	⊕ U = # O		Spean & Oas	٥٤ / 50	00 Univers	sity Blyd	. W. Si	lver S	pring	, MD 2090:
			23a. Part1. En y the disease, or complications that caused shock, or he art failure. List only one cause on each lin	the digth. Do not out	er the mode of dying	, such as cardiac	or respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease ir condition	Media	7-10	C111				Onset and Death
	/Medical Examiner		resulting in death) a Due to (or as a	a consequence of):		CVA				
Е	8 6	_	Sequentially list conditions b.	2 Riot	It they	4222	eri c	CHIC		
	ted 1sit	nin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of):		1 :				
	icate be executed physician and s the burial-transit	Examiner		consequence of):	BRI	LIAT	1010			
260	siciar buria	E I		, admod 4001100 01).						
68760,	tificate be execut g physician and as the burial-tran	edical	d							
Box	leath cert ettending for use a	2	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome in	of pregnancy						
	death e ette d for	Physician/M	in the past 12 months? 1□Live birth 1□Yes 2□No 4□Pregnant at		Ectopic pregnancy Other (specify)			23d. Date Mor	e of delivery oth D	/ Pay Year
P.0	that the dended by the e	hys	9 □ Unknown 9 □ Unknown		(4)					,
	requires that the death cer een signed by the ettendin hould be detached for use	by P	Part II. Other significant conditions contributing to death bu	t not resulting in the un	derlying cause giver	in Part I.	23e. Did toba	acco use contri	ibute to the	cause of death?
Records,	w require been sig should b	pe	PNEUMONIA.				1 ☐ Yes			bly 4 □Unknown
သွ	aw re Is bee	Completed					240 Wee			
Ä	The law is ate has be page 2 sh	E					24a. Was an autopsy performe	p	vere autops rior to comp eath?	sy findings available pletion of cause of
Vital		a	25. Was case referred to medical				1 Yes 2	No 1		□No
>	ysici is cer direc	LO B	examiner? 1 Yes 2 No Hospital: 1 Inpatier	t 2 ER/Outpatient	Other	26. Place of Death				
10.	ding Phi h, After thi funeral o		27. Manner of Death 28a. Date of Injury	28b Time of	3 LI DOM	4 LJ Nursing Hon	ne 5 ☐ Residen 8d. Describe how			
<u>ō</u>	ath. rr: Af ie fur	랿	1 Matural 5 Pending (Month, Day 2 Accident investigation	Year) Injury	28c. Injury a Work? M 1 □ Ye	es 2 🗆 No	ou. Describe non	rinjury occurre	eu .	
Division	il or Attendl after death, I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injur	y - At home, farm, stre			8f. Location (Stre	et and Numbe	r or Rural E	Pouto Number
Ö	tal or	등	building, etc.	(Бресіту)			City or Town,	State)	r or nurai n	loate rearriber,
	Hospital or Attending Physician: 24 hours after death, Funeral Director: After this certific itely filled in by the funeral director,		29a. Certifier (Check only (C	my knowledge, death	occurred at the time	, date and place. a	nd due to the cau	ise(s) and mar	ner as state	eri
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	(Check only one) 2 Medical Examiner: On the basis of and manner state	examination and/or invested.	estigation, in my opi	nion, death occurre	ed at the time, dat	e and place, a	nd due to th	ne cause(s)
	To To	2	29b. Signature and title of certifier		29c. License r		290	d. Date signed	(Month, Da	y, Year)
	41		M.D.		700	65024		0610	3/01	F09
-	5''		30. Name and address of person who completed cause of dea	ath (Item 23a) (Type, P	rint)				IN	D 2083
			MONTALE GOMA	, M 6	3H 118	165024 101 PRI	NCEP	HILIP	DR.	OLNEY
	Stat Registra		31. Date filed (Month, Day, Year) 32 Negistrar 32 Negistrar	's Signature	relle)					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2:34 am Ahmani May 26 2007 Marie Medley 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring Holy Cross Hospital Mongomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Days Hours 1 ☐ M 2 🖾 F None May 26, 2007 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 No None Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 510 Oglethorpe Street NW 20011 United States Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Specify: Black 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Benson Darrell Medley April Elizabeth Hugger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 Oglethorpe St. NW, Washington, DC 20011 April Medley / Mother Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 IC Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland Ft. Lincoln Crematory 6/5/2007 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part. Finer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prematurity Due to (or as a consequence of): Preterm delivery 22 weeks Due to (or as a consequence of) Incompetent Cervix

Physician /Medical Examiner

Physician

/Medical

10a. State

DC

Director

Funeral

þ

Completed

Be

ပ

Examiner

Funeral

Director

28a-f show

7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 9m 27 is marked other than "natural", or Itel

permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is
any injury or other trau

Baltimore, Maryland 21215-0036

burial-transit and physician the as for use the detached þ signed t peen page 2 s certificate has this e Hospital or Attending P 24 hours after death. e Funeral Director; After t After t

death certificate be executed

P.O. Box 68760

Division or Vital Records,

Physician:

24 hours a

within 2

completely

Certification: To funeral the filled in by Medical

Examine Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 Completed 25. Was case referred to medica examiner? Be 27. Manner of Death

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9 Unknown

2 No

29b. Signature and title of certifie

JUN

5 Pending investigation

6 Could not be

1 Tyes

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4☐Pregnant at time of death 9∏Unknown

1 Inpatient

and manner stated.

Due to (or as a consequence of):

3 Ectopic pregnancy 5 ☐ Other (specify)

24

23d. Date of delivery Month Day

Year

23e. Did tobacco use contribute to the cause of death?

1 Tes	2 🔀 No	3 ☐ Pro	bably	4 Unknow
a. Was an autopsy performed		Were aut prior to co death?	opsy fir ompleti	ndings available on of cause of
1 Yes 2 🛭			2 🗆 1	No

1 Yes 2 No 26. Place of Death (Check only one) pecify)

1 ☑ Inpatient	2 ER/Outpatient	3 DOA	4	□ Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)
28a. Date of Injury (Month, Day Yea	28b. Time of Injury	1	c. Injury at Work?		28d. Describe how injury occurred
		M	1 TYes	2 🗌 No	
28e. Place of injury - building, etc. (Sp	At home, farm, stree bec <i>ify)</i>	t, factory,	office		28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Hospital:

29c. License number D43041

Other

29d. Date signed (Month, Day, Year)

5-26-2007

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

Barbara J. Butler, M.D. 12215 Shady Grove Rd. #300, Rockville, MD 20815

State Registrar 31. Date filed (Month, Day, Year) 2007 05



2 ☐ ER/Outpatient

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
Otata of Manual and / Demontroport of I	lastik and Montal Livelana

	1	For State Registrar				, idii id		tificate		eath		Re	g. No.	007		1994
sician edical	1	. Decedent's Name	First, Middle, La	·	RICE	M	CK	ENZIE			Mor M A		Day 26H1	Year 2007		3. Time of Death
miner	4	a. Facility Name (If						4b. City, To	wn, or L	ocation of Death			4c. C	ounty of Dea	ath	
		Baltimore								urnie			Aı	nne Ar		
ral tor	C	. Social Security No 062-30-43	02	Sex 1 □ M 2 🛛 F	7. Age (I	69	t birthday) Yrs.	If Under 1 Months D		If Under 24 Hrs. Hours Min.	(Mo	of Birth onth, Day, 18,	Year) 193	0	rthplao country)	
	\vdash	Jsual Residence of 0a. State	10b. County		10		own or Lo								10d.	Inside City Lim
당	M	faryland	Anne Ar	undel		Od	lentor	1								
Director	1	0e. Street and Nur	mber					10f. Zip Co	ode			10	g. Citize	n of What C	Country	?
al		1212 Ode	nton Roa	d, Apt.	414				113				nite	ed Sta	tes	
/ Funeral	1	_	ied 2□ Married	12. Was Dec Armed For 1 Tyes If Yes, G	orces?	er in U.S.		Was Deceder f Yes, specity f □ Yes 2 X		panic Origin? (Sp , Mexican, Puerto Specify:	pecity Ye o Rican, o	s or No- etc.)	5	 Race - Arr Black, Wh Specify: 	ite, etc	
ed by		3 ☐ Widowed	15. Decedent's E	Year or E	Dates:		16a. Deced	ient's Usual (Occupat	ion		1	A:	frican d of Busines		erican
Completed	-	(Spec	ondary (0-12)) (1-4or 5+)					ring most of wor	king		Ca1:	f-Emp1	0770	ď
ပိ	-	12	15: 1 A S. S. S. S. S. S. S. S. S. S. S. S. S.	4)			Inter	cior De		18. Mother's Nam	no /First	Middle N			Оус	<u> </u>
Be	1	17. Father's Name ((r-Irsī, Middle, Las	i)						Zenobia				amame)		
은	L	Unknown														
		19a. Informant's Na						-		nd Number or Ru						
1		Stephen M		Son						Terrac						21113
once. To Be Completed by Funeral Director	2	20a. Method of Disp 1 ☐ Burial 2 4 ☐ Donation	osition ☑Cremation 3 [5 ☐ Other (Spec	□Removal from	State	cen	netery, cier L inc o		er place emat	ory 5/31	Date / 07			entwoo		Marylan
once.		21. Signature of Fu	uneral Service Lice	A See			S:	Name and in Place 1	Address Trib ckvi	of Facility oute Fun Llle Pik	eral e. R	and ocky	Cre	matior • MD	1 Ce 208	nter 352
Medical Certification: To Be Completed by Physician/Medical Examiner	23a. Part1. Ent r the disease, or c. Implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. ARTERIAL ISSUE ARTERIAL ISS													34/2		
Physician/Med		IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 9 □ Unknowh	months?		birth 2	Fetal d	eath 3	⊒Ectopic prec ⊒ Other <i>(sp</i> ec					23	3d. Date of o	,	ay Year
d by Ph		Part II. Other signi	ificant conditions	contributing to	death but i	not result	ing in the u	nderlying cau	ise give	n in Part I.	23		acco us		to the	cause of death
Completed	1											la. Was al autops perforr Yes 2	У	24b. Were prior t death	o comp	y findings avail pletion of cause
Š	ŀ	25. Was case refe	rred to medical							26. Place of Dea			/			90.10
Be		examiner?	Α	Hospital:	A)nnationt	2 [] F	R/Outnation	nt 3 DOA	Othe					Other /S	necify)	
tion: To	-	27. Manner of Dea		28a. Date (Mo	e of Injury onth, Day	2	8b. Time o		c. Injury Work		1	escribe ho			poony	
Certification:		2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	be 28e. Plac	ce of Injury Iding, etc.	/ - At hom (Specify)	ne, farm, st	reet, factory,	office			cation (St ty or Town		f Number or	Rural I	Route Number,
Medical C	-	29a. Certifier (Check only one)	Certifying F	aminer: On the		xaminatio				e, date and place pinion, death occ						
Me	-	29b. Signature and	d title of certifier					29c.	License	number		2	9d. Date	e signed (Mo	onth, D	ay, Year)
		Proor	ma m	· Eur					000	54739	!		MAY	1 27	4 2	007.
		30. Name and add							Ave.	, Balti	more	, MD	21	215		
State		31. Date filed (Mor	nth, Day, Year)	107	Registrar	's Signatu	ire do	A. 6								

			1 - For State Registrar	State of Ma	arylan	-	artmen rtificat				ental H	/gie		7		
			1. Decedent's Name (First, Middle,	Last)	-		-				2. Date of D		Day Ye	ear	3. Time of	Death
	Physici /Medic		Paul Winston M	cIntire, Jr	•						June	6,	2007	Jai	11:10) A.M
	Examin		4a. Facility Name (If not institution,	give street and number)			4b. City,	Town, or	Location o	of Death			4c. County of I	Death		
н			Oakwood East A	partments,	110 /	A St.	Mt	n. La	ake P	ark			Garrett			
	Funeral		5. Social Security Number 6		e (In yrs.	last birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of B (Month, D	irth ay, Ye	ar) 9.	Birthpla Counti	ce (State or	r Foreign
	Director	,	216-30-2097	¹X ^M 2□ F 7:	3	Yrs.							1934 N	lary	land	
	and *		Usuel Residence of Decedent 10a, State 10b, County		10c. Cit	y, Town or Lo	ocation							10	d. Inside Cit	v Limits
	Aaryl eho	5	MD Garre	++		•		1_							1 ☑ Yes	-
	280-	Director	10e. Street and Number		MLI	n. Lak	10f. Zip					100	Citizen of Wha	t Countr	n/2	
	with Se or	<u>a</u>	110 A Street					1550				_				
	leath	Funeral	110 A. Street	12. Was Decedent 8	Ever in U.	.S. 13.			spanic Orio	gin? (Spe	cify Yes or N		ited St			
10	riter	필	1 ☐ Never Married 2 ☐ Marrie	Armed Forces?	lo		If Yes, spe	city Cubai	n, Mexican	i, Puerto	Rican, etc.)			White, e		
ő	ei'. o	by	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates:			1 🗆 Yes	2 🔼 No	Specify:				Specify:	hit	e	
2-0	within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28e-f ehow the Madical Exeminer must be notified at	Completed	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usua	al Occupa	ation	t of worki	na	16b	. Kind of Busin	ess/Indu	ıstry	
2	thin thin	ng l	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	kind of wo DO NOT u	se retired,)	i or works	'9					
2	filed w Hygien other th	ပ်		3+		Reta	ail S	ales					ardware	<u>:</u>		
בַ	be fill ital H id oth	Be	17. Father's Name (First, Middle, La						18. Mothe	er's Name	(First, Middl	e, Maio	den Sumame)			
<u> </u>	ould Men Marke	ဥ	Paul W. McInti								McComa					
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hygiene. Deperment of Heelih and Mental Hygiene. Deperment of Heelih and Mental Hygiene. Deperment of Heelih and Medical Examinations or 28e-1 show eny injury or other treumatic event, the Madical Examinations must be notified at ODCe.		19a. Informant's Name/Relationship										ty or Town, Sta			
e)	1 and 1eelt 1m 2 ther		Mr. David L. Mo	cintire, Soi							e, Dam	_	us, MD . Location - Cit		0872	
ō	Pages nent of h int: If its		1 Burial 2 Cremation 3	Removal from State		Place of Dispo cemetery, crei			1	_		200	. Location - Cit	yorlow	m, State	
	tmer tant		4 ☐ Donation 5 ☐ Other (Spe		Cı	ımberla					2007	C.	umberla	nd,	MD	
Baltimore,	Depending Permit	l	21. Signature of Funeral Service Lie			22	2. Name ar Davi	d A.	Burd	ock .	Funera	1 H	ome, P.	Α.		
_	40100		23a. Part1. Enter the disease, or co	Sweiner	the death	Do	21 N	. Sec	cond	St.,	0akla	nd,	MD 215	50	Approximate	
			shock, or heart failure. List or	nly one caus on each lin	10.	n. Do not em	er the mod	ie or dymi	y, such as	Cardiaco	respiratory	arrest,			Interval Betw Onset and D	veen
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Pancreat			oma							1	lyear	
	Examiner			Due to (or as a	a conseq	uence of):										
		-	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a	a conseq	uence of):								_		
	nsit	Examiner	Cause (Disease or injury		,											
_^	ai-tra	Xai	that initiated events resulting in death) Last	C Due to (or as a	a conseq	uence of):					-					
760,	The law requires that the death certificate be executed the has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit			d												
68	ificate g phy as the	Physician/Medical		U	-				-							
Вох	death certifica ettending ph d for use as th	N N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			7						23d. Date o	f deliver	y	
Ď.	death e ette d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1∐Live birth 4∐Pregnant at			∃Ectopic pi ∃Other (sp						Month		Day Y	'ear
о. О.	t the by th tache	hys	9 □ Unknown	9□ Unknown												
	w requires that the de been signed by the s should be detached	by P	Part II. Other significant condition	s contributing to death be	ut not res	ulting in the u	nderlying o	ause give	n in Part I.		23e. Did	tobaco	o use contribu	te to the	cause of de	eath?
Ë	quire an sig	ed	severe coronary	artery dis	ease						1 🗆	Yes	2 No 3	Proba	bly 4 🖯 U	nknown
ပ္သ	aw re is be	piet	severe peripher	al vascular	dis	ease					24a. Wa		24b. Wer	e autops	sy findings a pletion of ca	vailable
č	hysicien: The law his certificete has b I director, page 2 s	Completed										opsy formed	?dea	th? Yes 2		luse or
<u>ia</u>	len: rtifice stor, p	0	25. Was case referred to medical	4					26. Place	of Death	(Check only		110			
>	Attending Physiclen: r death. ector: After this certifice by the funeral director, i	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	nt 2 🗆	ER/Outpatier	nt _ 3 🗆 DC	Othe	er: 4 □ Nu	irsing Hor	ne 5 Res	sidence	6 □Other (Specify)		
0	ding Phy th. After thi funeral		27. Manne Ceath 1 atural 5 ☐ Pending	28a. Date of Injur (Month, Day	y (Year)	28b. Time o	f 2	8c. Injury Work	at				njury occurred			
Ö	uttendir death. ctor: Af y the fu	atic	2 ☐ Accident investiga	tion		,,	М		res 2 □ 1	No						
Division of Vital Records,	r Attend ter death rector: n by the	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ry - At ho	ome, farm, str	eet, factory	y, office		2	28f. Location City or To		and Number o	r Rural	Route Numb	ber,
	itei or irs afte rei Dir led in	S														
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	icai	(Check only 2 Medical E)	Physician: To the best of caminer: On the basis of	examina	wledge, deat	h occurred vestigation	at the tim	e, date an	d place, a	and due to the	cause , date	e(s) and manne and place, and	er as sta	ted. the cause(s))
	To the h within 24 To the F complete	Medicai	one)	and manner sta	ted.											
	N T S	-	29b. Signature and title of certifier	11.1			290	. License	number	> >		290.	Date signed (A	nonth, D	ay, rear)	
			/	THOU	W			1	1 5	> 5_	\$		410	11	1)	
		2	30. Name and address of person w					t	0-17	1 1	MD (11 -	. 0		/	
	Sta		Thomas G. Johns 31. Date filed (Month, Day, Year)	32 Registra		Fourt	II STY	eet	Uak.	tand,		2155	υ			
1	Registr		JUN - 8	1 1	an d		and A									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Year **Physician** 106 PM 07 2007 June EARL LUTHER McLUCAS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WASHINGTON HAGERSTOWN WASHINGTON COUNTY HOSPITAL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days 1⊠M 2□F 26,1921 MARYLAND Director 220-05-6996 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 Yes 2 No Director FUNKSTOWN MARYLAND WASHINGTON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21734 U.S.A. 601 SOUTH EDGEWOOD DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 🔀 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. ģ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical than College (1-4or 5+) Elementary/Secondary (0-12) MILK TRANSPORTATION 10 TRUCK DRIVER marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be finance and Mental F AMY VIOLA MOSER SAMUEL LUTHER McLUCAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 9 permit. Pages 1 and 2:
Department of Health at
Important: If item 27 is
any injury or other trau SUSIE M. McLUCAS/SPOUSE P.O. BOX 775, FUNKSTOWN, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Ponation 5 □ Other (Specify) 6/11/2007 WOLFSVILLE, MARYLAND SALEM U.M. CEMETERY 22. Name and Address of Facility 7606 Old NationalPike 21. Signature Fune lai Se BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician orona /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner ng physician and as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? ent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by page 2 2 Be မ Certification:

the Hospital or Attending Physician: The law requires that the death certificate be executed after death.

| Director: / within 24 hours after
To the Funeral Dir

art II. Other signii	Emply		n ų							1 Yes 2 No 3 □	☐ Probably 4 ☐ l	Unknown
5. Was case refer	red to medical			-			26.	Place of Dea	th (Check only one)		
examiner? 1 ☐ Yes 2 ☐	Ńο	Hospital:	1 npatient 2	ER/Outpatient	3 🗆 1	DOA	Other: 4	I ☐ Nursing H	ome	e 5 ☐ Residence 6 ☐ Other (5	Specify)	
7. Manner of Deatl 1 Natural 2 Accident	h 5 □ Pending investigation		Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 Yes	2 🗆 No	28	d. Describe how injury occurred		
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e.	Place of injury - At h building, etc. (Speci	ome, farm, stree	t, fact	ory, o	ffice		28	f. Location (Street and Number o City or Town, State)	or Rural Route Nun	nber,
29a. Certifier (Check only	1 Certifying Ph 2 Medical Exam	niner: On	To the best of my known the basis of examin	owledge, death ation and/or inve	occurre	ed at t	the time, o	date and place on, death occu	e, an	d due to the cause(s) and manne d at the time, date and place, and	er as stated. I due to the cause(s)

DJ8471

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUN 0 8 2007

er

State Registrar

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year 5:33 June PM Robert Startzman Martin Q 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, Year) May 4 1917 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex. 1 2 M 2 ☐ F Days Months Hours 90 Maryland 219-05-2201 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Washington Hagerstown 1X Yes 2 □ No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 U.S.A. 549 Highland Way 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 Tho Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white Specify. 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie E. Martin Laura Startzman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4965 East Rittenhouse Drive Port Clinton Ohio 43452 Barbara A. Hutchinson daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Grace UCC Ch. Cemetery 6-9-07 Tanneytown Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses Kaitten. 1331 Eastern Blvd. N. Hagerstown Maryland 21742) at ron 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Carlina les mis Due to (or as a consequence of): cores Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ALLI Due to (or as a consequence of) uis varau anie. Scharlie IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 I Inknown own

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be 2

Funeral

Director

2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f sh any injury or other traumatic event, the Me Iteal Examiner must be notified a once.

Baltimore, Maryland 21215-0036

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

State

Registrar

burial-tran ed by the attending physician detached for use as the buria pe Hospital or Attending To the Hospital of within 24 hours at To the Funeral D

Division or Vital Records, P.O. Box 68760

O LI OTTICIO STATE					
Part II. Other significant condition	ons contributing to death but not res	sulting in the underlying	g cause given in Part I.		use contribute to the cause of death
				24a. Was an autopsy performed? 1∐ Yes 2. ☑	
25. Was case referred to medical			26. Place of D	eath (Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 4 patient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investig		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred
3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi			tory, office	28f. Location (Street a City or Town, State	nd Number or Rural Route Number, te)
	g Physician: To the best of my kn Examiner: On the basis of examin and manner stated.				
29b. Signature and title of certifier		1	29c. License number	29d. D	ate signed (Month, Day, Year)

18019

5-7

JUNE

MAGELS TOWN

7,2000

MD 21740

SH-25

31. Date filed (Month, Day, Year) JUN 0 8 2007

OUT MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DATTAMO

32. Registrar's Signature

340

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JUNE **Physician** ROSE NEWSOME 1 3 ELMA 2007 10:35 a^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Chester River Hospital Chestertown Kent If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) NOV 27 19 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 ☐ M 2 🛣 F Yrs. Director 69 1937 Maryland 212-34-1629 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral, or itama 23a or 28e-f ahow Examiner must be notified at 1 ☐ Yes 2X No Director MD Kent Worton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24461 Lambs Meadow Rd. 21678 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Heelth and Mental Hygiene Important: If itam 27 is marked other than "natural", or itam any Injury or other traumatic event, the Medical Frances 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Edward Whiteley Flora Mae Dickerson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21678 19a. Informant's Name/Relationship (Type, Print) (husband) 24461 Lambs Meadow Rd. Worton, MD. Richard L. Newsome Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Remoyat from State Chester Cemetery 6/19/07 Chestertown, MD. 4 □ Donation 5 □ Other (Specify) 21. Signature of Eulieral Service Lic 22. Name and Address of Facility
Galena Funeral Home of Stephen L.
118 West Cross St. Galena, MD. 21 Schaech M00510 21635 Page: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition CAPDIDRESPIRATURY **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner RHEUMATOIN ARTHEITE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed DEPRESSION resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š GRAINES 1 Yes 2 No 3 Probably 4 Unknown Completed STIPATION. 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? REFLUX DIBENGE GASTRUZGUPHAGEAL 1 Yes 2. No 1 Tes 2 No or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Tyes 2 ₺No After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death. To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 55043 M int- lun wek 30. Name and address of person 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 0 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Phil Avery Norma	1	- For State	tate of Maryl	•	artment of <i>tificate of</i>		nd Men	tal Hygi		2 [] g. No.	07 1995
Physiciar Medical Examin	n/	Registrar 1. Decedent's Name (First, Middo PHIL AVER		AN, SR.				Λ.	Date of Death Month une 13, 2	n Day Year	3. Time of Death 0940 hrs
		4a. Facility Name (if not institution 10179 Oriole Lane	on, give street and r	number)	4	b. City, Town, Millington	or Location o			4c. County of Di	eath
Funeral	7	5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Ye			. Date of Birt		Birthplace (State or preign
Director	1	228-84-1803	1 X M 2 F	53	Yrs	Months Da	ys Hours	Min. M	ar 4	1954	Country) Virgini
e a ye at payment a glass areas.	·	Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Locati	O.D.					10d. Inside City Limits
ow any		MD Ker		1	illing						1 Yes 2 XNo
ryland a-f sh	횽	10e. Street and Number				10f. Zip Code			I 10	g. Citizen of What 0	
	o e	10179 Oriole				216	51			U.S.A.	<u> </u>
ith wit	Funeral	11. Marital Status 1 Never Married 2 N		ecedent Ever in U Forces?		s Decedent of I es, specify Cub				14. Race - Al White, et	merican Indian, Black, cc.
ter dea			1 Yes	2 X No	1	Yes 2X	lo specify:			Specify:	White
urs af	g S	15. Decedent's Education (Spe	l or Dates:		16a. Deceden	's Usual Occup	ation (Give			16b. Kind of Busine	
6 72 hc ra firs	leted	Elementary/Secondary (0-12)) College	(1-4 or 5+)	_	ost of working li	te. DO NOT	use retired)		0.16	
OO3(within iene er tha Medii	Comple	12			Pai	nter	Tions a				employed
215-0036 be filed within 7 trial Hygiene. rked other than ent, the Medica	8	17. Father's Name (First, Middle George Norm					Anr	n Gri	ffin	Maiden Surname)	
MD 21 d 2 should 1 Ith and Mer n 27 is mar aumatic ev	- 1	19a. Informant's Name/Relation Phil A. Norm		(son)							State, Zip Code) 1971 ark, DE.
e, C. I and I and Healti	ı	20a. Method of Disposition	. — .		Place of Dispos crematory or oth		emetery,	Da	ate	20c. Location - Cit	y or Town, State
Baltimore, permit. Pages la Departament of ite Important: If ite		Burial 2 XCremation 4 Donation 5 Other S		nom otate	ent Cr		n	6/14	1/07	Smyrna	, DE.
altir mit. 1 partm porta ury o	t	21. Signature of uner Service	icensite	97	22. N	ame and Addre	ss of Facility	y l Ho	me o	f Stophe	n L. Schaed
E E E E			104	MO0	• • • • • •	X West	('ro	99 ST	· (+a	lena Mi	21635
Physician /Medical		23a. Part I. Enter the disease, o failure. List only one cause	e on each line.					ardiac or res	spiratory arre	est, shock, or heart	Approximate Interval Between Onset and
xaminer	1	Immediate Couse (Final disease or condition resulting in death)		sive Atheroscl		ovascular D	isease				Death
	1		b.	a consequence of	n).						
	jē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		a consequence o	of):						
	Examiner	(Disease or injury that initiated events resulting in death) Last	C.	a consequence of	of):			_			
		events resulting in deathly Last	d	, and the second							
0, C. be executed sician and ourial - transit	edical	UNPENDED	AMENDED)							
760, icate be on physicia the buria	ğ	IF FEMALE: 23b. Was decedent pregnant in		s, outcome of preg			. —			23d. Date of del	
certifica	sician/M	past 12 months?	ı 🗀 rive	birth gnant at time of de		tal death s ner (Specify)	BEctopie	c pregnancy		Month	Day Year
Vital Records, P.O. Box 6876 siring and retrificate by secrificate has been signed by the attending phydirector, page 2 should be detached for use as the increase.	hysi	1 Yes 2 No 9 Ur	alemanum =	nown	3 00	ler (Specify)					
on the set of by the etache	₽.	Part II. Other significant cond	itions contributing	to death but not r	esulting in the u	nderlying caus	e given in Pa	art I.			te to the cause of death?
S, P Lires th 1 signe d be d	ed by		.	·-·				— W			Probably 4 Unknown
ord: w requas been as been	Bet								24a. Was a autop	sy prio	re autopsy findings available in to completion of cause of
Rec The la	Completed								perfor		Yes 2 No
ian: certifi	e l	25. Was case referred to medic examiner?					Other	(Check only			
F Vit Physic or this	ટ	1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient		njury at Work	Nursing H		Residence 6 🗸 0	Other: Scene
n of \ding Phy ding Phy h. After tl		27. Manner of Death 1 ✓ Natural 5 Per	(Mor	te of Injury hth, Day,Year)	Zob, Time of t	· · _	Yes 2	_	u. Describe i	low injury occurred	
ivision or Atteno after death Director:	cati	2 Accident Inve	estigation 28e Pla	ace of Injury - At h	ome farm stree				f. Location (S	Street and Number of	or Rural Route Number, City
Division of Vital Records, pital or Attending Physician: The law requir ours after death. eral Director: After this certificate has been so the function of the thin certificate has been so the thin the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director that the funer	Certification		uld not be 20e.116 ermined (Specif		onio, iaini, ai e	,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	banag, e.		or Town, S		., , , , , , , , , , , , , , , , , , ,
hou hou		29a. Certifier 1 Certifying F								e(s) and manner as	
To the Hos within 24 h	Medical	one) 2 Medical Ex	aminer:On the basi and manner	s of examination a	and/or investigat	ion, in my opini	on, death oc	curred at the	e time, date	and place, and due	to the cause(s)
F % F 8	ğ	29b Signature and title of certif				29c. Lice	nse number			29d. Date signed	(Month, Day, Year)
		1 ant	aletho)			0.0	C.M.E.			June 14, 200	7
4	ļ	30 Name and address of perso Laron Locke MD.	n who completed ca Assistant Medic		,	Street, Bal	timore, M	ID 21201		• · · · · · · · · · · · · · · · · · · ·	
Sta	77.	31. Date filed (Month, Day, Year	32.4	egistrar's Signat							
Registr	ar	JUN 2	0_2007 20	lasuar A	100						

For Amend Item 31 State of Maryland / Department of Health and Mental Hygiene State Registrar WCHD/SH 6/6/07 per VR Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 8:42AM Cletus NESMITH Herman 2, 2007 June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Williamsport 16314 Lappans Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F 72 Yrs 236-48-3654 Director May 18, West Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other then "naturel", or items 23a or 28e-f show traumatic event, the Medical Examinar must be usuffied at Williamsport 1 ☐ Yes 2 ☑ No Maryland Washington Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? U.S.A. 21795 16314 Lappans Road death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No white Specify Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within al Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) driver trucking company permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: if item 27 Is marked othery injury or other traumatic event, pages. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Martha Pearl Catlett Irving Preston Nesmith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16314 Lappans Road, Williamsport, Maryland 21795 Nellie M. Nesmith - wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 6 Greenlawn Memorial 2007 Williamsport, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and c. physicien ar s the burial-ti Due to (or as a consequence of) Box 68760, Physiclan/Medical as attending IF FFMALE 980 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 I ive birth 2 Fetal death ō in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. the 9☐ Unknown à signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 2 No 3 ☐ Probably 4 ☐ Unknown 1 TYes page 2 should Completed Deen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an hes autopsy performed? res 22.No certificate 2 No 1 Yes Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient ဥ 1 Tes 3□ DQA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Certifying Physician: T. (the), est of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medica: Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical (Check only one) asis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) for stated. 29b. Signatu 0056826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9St. Paul Street Boonsborg, MD 21713 Practice South Mt. Family 145+1 31. Date filed (Month, Day 6 2007. Registar's Signature State Registrar

			1 - For State Registrar	State of	Marylai	nd / Depa <i>Ce</i>		nt of H te of L		and M	ental H	ygie Reg.	Eron Nr.	<i>.</i>	
			Decedent's Name (First, Middle, Last	it)						}	2. Date of I		Day	Year	3. Time of Death
	Physici /Medi	cal	Elizabeth Killeer				45 65	Town or	l continu	4 D - 45	June	4,		7	9:00 P M
	Examir	ner	4a. Facility Name (If not institution, given Manor Care-Potoma		<i>Derj</i>		Poton	, Town, or nac	Location o	of Death			4c. County Monto		У
	Funeral		5. Social Security Number 6. S		. Age (In yrs	. last birthday)	If Unde	r 1 Year Days	If Under 2	24 Hrs.	8. Date of E	Birth		9. Birthp	lace (State or Foreign
Ļ,	Director		5/8-66-6314	□M 240F	91	Yrs.	Wioritis	Days	Tiours	Will,	July	7, 1	915	New	Jersey
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	ocation							1	Od. Inside City Limits
	Mary P-f sh	tor	Maryland Mor	tgomery		Ве	thesd	la							1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number		•		10f. Zi	p Code				10g.	Citizen of	What Coun	ntry?
	ath w	rai	6904 River Road				208						JSA		
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "netural; or Items 23s or 28e-f show other traumatic event, The Medical Examinational De notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Dat	ces? 2.[3 [No		Was Dece If Yes, spe 1 Yes	cify Cubar	spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto l	cify Yes or I Rican, etc.)	No-	Bla	ce - Americ ck, White, y: Whi t	etc.
	2 hou	Completed by	15. Decedent's Ed	ucation		16a. Dece						166	. Kind of B	usiness/Ind	dustry
	within 7 ene. thsn "r he Med	npie	(Specify only highest gra	College (1-	4or 5+)	life.	DO NOT L	ork done di ise retired)	unng most	of workir	ng				
	filed w Hygier ther th		12 17. Father's Name (First, Middle, Last)			Ho	nemak		40 14 15		/F:		Own H		
	d be find Head of	Be c	John Stephen Kil	leen							(First, Midd rances			ne)	
•	should and Ment	2	19a. Informant's Name/Relationship (1			19b. Maili	na Addres	s (Street a			l Route Nun			State, Zip	Code)
	1 and 2 s Health an Iem 27 Is		Martin Michael O'	Connor/	Son										FL 33483
	permit. Pages 1 an Department of Heal Importent: If Item 2 any injury or other once.		20a. Method of Disposition 1 ★ Burial 2 Cremation 3 4 Donation 5 Other (Specify		tate	Place of Dispo cemetery, crei	matory or	other place	·	June 200	•		Location -		
	permit. Departm Importe any inju		21. Signature of Juneral Service Licen	500	0	F	Name a	nd Address	s of Facility		/ Funera		shing Lome I		DC
·	907 5 9 9	. 17	Muchen	Les	le	5	00 Un	ivers	sity	Blvd	, W.,	Sil			MD 2090
1	Physician /Medical	,	23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aA	ch line.	ned					r respiratory	arrest,			Approximate Interval Between Onset and Death
	Examiner		Convention list conditions	b		4401.00 01).									
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		r as a consec	quence of):									
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (o	r as a consec	Tuence of):									
	ificate be executed g physician and as the burial-transit	aiE			as a consec	querice or).									
	ificate g phys	edicai	•	d											
	The law requires that the death certif tte has been signed by the attending bage 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ∏ Feta ntattime of o	al death 3□	Ectopic p Other (s _i						23d. Da Mo	te of delive inth	ry Day Year
	that the ed by detac	/ Ph	Part II. Other significant conditions of	ontributing to dea	ith but not res	sulting in the u	nderlying o	cause give	n in Part J.		23e. Dio	l tobaco	co use cont	ribute to th	e cause of death?
	w requires been sign should be	ed by				3									ably 4 Aunknown
	e law re has be je 2 sho	Completed									24a. Wa	is an	24b. \	Were autop	osy findings available
		Con									per 1 ☐ Yes	formed		death? 1 🗌 Yes	npletion of cause of 2 X No
	iicisn: Th certificate rector, pag	Be	25. Was case reterred to medical examiner?	Hospital: ,						of Death	(Check only	one)			
	ding Physicisn: The n. n. After this certificate ha funeral director, page	-: To	1 Yes 2 No 27. Manner of Death	. 1 🗆 lnl		28b. Time of			4 pc Nur		ne 5 Re				')
		ition	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of (Month,	Day Year)	Injury	м	28c. Injury Work' 1 🗌 Y	es 2 □ N			J 11044 II	ijary occurr		
	ol or Attending Physicisn; after death. I Director: After this certifice d in by the funeral director, g	ertification;	3 Suicide 6 Could not be determined	286. Place 0	f Injury - At h g, etc. (Speci	ome, farm, str fy)	eet, factor	y, office		2	8f. Location City or T			er or Rura	Route Number,
1	To the Hospitel or Atten Within 24 hours after deat To the Furiers Director: completely illed in by the	edical C	29a. Certifier (Check only one) 2 Medical Exam	ysician: To the b iner: On the bas and manne	is of examina	owledge, death ation and/or in	n occurred vestigation	at the time	e, date and nion, deat	d place, a h occurre	nd due to the	e cause e, date :	e(s) and ma and place,	inner as stand due to	ated. the cause(s)
	To the To the comple	M	29b. Signature and title of certifier					c. License				29d.	Date signer	d (Month, L	Day, Year)
-	5		12/	* •			Y.	005	545	66		. 6	6151	07	
			30. Name and address of person who	ompleted cause	of death (Iter	m 23a) (Type,	100	Lan	1 2 -	a he	14.4		of the second	con	209ds
	Sta	te	31. Date filed (Month, Day, Year)	32, Re	istrar's Signa	ature	P LE COL	t re	rir ex.C	7, 7	N. V.	0	1	1 (2)	e jas
	Registr		ILIN 0 6 20	17	can a di	y. An	West								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** 2007 June 11 2:50 P.M Douglas Ray Oxford, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Dennett Road Manor Nursing Home 0akland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director 379-32-1764 Feb 14, 1935 Michigan Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f ehov item 27 ie marked other than "natural", or iteme 23a or 28a-f ebov other traumatic event, the Madical Examinar must be notified at 1 TyYes 2 □ No Director MD 0akland Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with thent of Health and Mental Hyglene. Int: if item 27 ie marked other than "natural", or iteme 23a or: 16 S. Second Street 21550 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

**Waxy'es 2 □ No
If Yes, Give 1952 1
Year or Dates: 1975 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1952 to 1 ☐ Yes 2 ☐ No Specify 3 ☐ Widowed 4 XDivorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Retired Military / Accountant Military / US Gov. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Herschol Wayne Oxford Marian Evelyn Clemence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Health if Douglas R. Oxford, Jr., Son 222 Bradley Lane, Oakland, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department c importent: if eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 6/16/2007 Oakland Cemetery Oakland, MD 21. Signature of Funeral Service Licensee ²² Name and Address of Faculity
David A. Burdock Funeral Home, P.A. Ducityer Katherine 21 N. Second St., Oakland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Colon ncer Ca /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 DEctopic pregnancy Month Day Year 4□Pregnant at time of death been signed by the a should be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 Yes 2□ No 1□ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 1 Tes 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient Nursing Home 5 Residence 6 Other (Specify) 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 29a Certifier Z | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) MI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 3 2001 Registrar

1-

29b. Signature and title of certifier

Physician /Medical

Examiner

Director

Funeral

by

Be Completed

ပ

Examine

Physician/Medical

Medical Certification: To Be Completed by

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at ounce.

Physician /Medical

	Please		Print in Blac				•	_	e.	
For State Registrar		State of	Maryland / [artment of H rtificate of		, 0	iene eg. No.	7 [
Decedent's Nam	ne (First, Middle, L	ast)					2. Date of Deat	5 .00	3. Tir	me of Death
	Geor	ge Barke	r Prettyma	ın.	Sr.		June	11 200 Ye	ar 220	00 PM
4a. Facility Name (or Location of Deat		4c. County of [
			icott City			tt City	_	Howar	d	
5. Social Security N 212-20-8	574	Sex 1MM 2□F	7. Age (<i>In yrs, last bir</i> 94	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min,	8. Date of Birth (Month, Day, DEC 15,	Year)	Birthplace (S Country) larylan	tate or Foreign
Usual Residence of 10a. State	f Decedent 10b. County		10c. City, Town	n or Lo	cation				10d Inei	de City Limits
		1								Yes 2 No
Maryland 10e. Street and Nu	Howar	a	ETTI	cot	t City		11	og. Citizen of Wha	t Country?	
5330 Dor	sev Hall	Drive			21042			United		
11. Marital Status	bej narr		dent Ever in U.S.	13.		lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No-	14. Race - A	American India	
1 ☐ Never Marr 3 🛣 Widowed	ried 2 Married	1 Tes 2 If Yes, Give Year or Da	2 ∑ No		ir res, specily Cub 1 □ Yes 2 ሺ No	an, mexican, Puen Specify:	o Rican, etc.)	Specify:	White, etc. White	
	15. Decedent's E	Education		Deced	dent's Usual Occup	pation		16b. Kind of Busine		
(Spec	ondary (0-12)	College (1- 5+				during most of word inistrate		Educat:	ion	
17. Father's Name	(First, Middle, Las	st)					ne (First, Middle, M			
Joh	n Pretty	nan				Gra	ce Clend	aniel		
19a. Informant's Na	ame/Relationship	(Type. Print)	19b.	Mailir	ig Address (Street	and Number or Ru	ıral Route Number,	City or Town, Sta	te, Zip Code)	
Susan Pret	tyman Lewis	s/Granddaug					Seattle	, WA 981	103	
		□Removal from S	late		sition (Name of natory or other place k Cemete:	, ounc	≥ 15 ,	20c. Location - City		
21. Signature of Fu	uneral Service Lice	ensee		122 H 1	. Name and Addre	ss of Facility	erals, P.	Δ	nar j re	
Don	will -	8. Hic	ha	10	3 W. Sto	ckton St	reet, Elk	ton, Mar	yland 2	21921
shock, or hea Immediate Cause (disease or conditio	ırt failure. List onl _! (Final	y one cause on ea	used the death. Do n ch line. Congestive or as a consequence of				or respiratory arre	st,	Onset	ximate al Between and Death
resulting in death)										
Sequentially list co	nditions,	b. Due to le	Ayperten	510	m				40	ars
cause. Enter Unde Cause (Disease or	erlying injury	Dire to fo	r as/arconsiau/lango 2	MI)C					1) "	
that initiated events resulting in death) I	3	c Due to (o	r as a consequence of	of):						
		d								
IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ☐ No	1 ☐Live bir	ome pf pregnancy th 2 Fetal death nt at time of death vn		Ectopic pregnancy Other (specify)	/		23d. Date of Month	delivery Day	Year
	,		ith but not resulting in	the ur	derlying cause giv	en in Part I.		acco use contribut		
- ren	al pual	ure					1 TYe	s 2 No 3	Probably	4 Unknown
read	al fail	ure					24a. Was an autopsy perform	prior deat	to completion h?	
25. Was case reference examiner?	red to medical						th (Check only one			
1 Yes 2		Hospital: 1 In	patient 2 ER/Out			4 LI Nursing H	ome 5 X Reside	nce 6 Other (S	Specify)	
27. Manner of Death 1 ☑ Natural 2 ☑ Accident	h 5 ☐ Pending investigatio			ime of ijury	28c. Injur Wor M 1 🔲	yat k? Yes 2 ∐ No	28d. Describe ho	w injury occurred		
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place o	of injury - At home, far g, etc. <i>(Specify)</i>	m, stre	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or State)	r Rural Route	Number,
29a. Certifier (Check only one)	1 Certifying P 2 Medicai Exa	hysician: To the b miner: On the bas and manne	est of my knowledge sis of examination and er stated.	, death d/or inv	occurred at the tir	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and manne ite and place, and	r as stated. due to the car	use(s)

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit physician and s the burial-transit attending ph for use as t certificate has been signed by the rector, page 2 should be detached

> State Registrar

DHMH 17 Rev 1/2001

CAMSON

CARLSON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BISHOCK

29c. License number

D0053636

10100 charter Dine Columbia

29d. Date signed (Month, Day, Year)

June 13, 2007

J.

Mary

			1-
	Physici	an	1. De
	/Medic	cal	
,	Examir	ner	4a. F
	Funeral		5. So 57 Usua 10a. Ma
Б	Director		57
	ъ ,		Usua
	ermit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan spartment of Health and Mental Hygiene. sportant: If item 27 is marked other than "natural", or Items 23a or 28a-f show yo injury or other traumatic event, the Medical Examiner must be notified at hea.	5	Ma-
	the N 28a-f notifie	ect	10e.
	with Sa or t be r		30
	death ms 2; mus	Jera	11. N
စ	after or Ite	Ē	1
8	ours iral",	db	3
5	"natu	ete	
12	withir ene. than be Me	To Be Completed by Funeral Director	El
2	rmit. Pages 1 and 2 should be filed within spartment of Health and Mental Hygiene. portant: If item 27 is marked other than I'v Injury or other traumatic event, the Melos.	Ö	17. F
<u>a</u>	uld be fenta rked ric ev	.o. B	
ary	should be should	-	19a
Σ	and 2 salth n 27 i		Pa
ore	Jes 1 If iten		20a.
Ē	. Pag tment tant: jury o		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21.
			23a
	Physician		lmm
	/Medical		dise resu
	Examiner		0.00
3	uted Insit	miner	Se it an caus Caus that
o,	be executed sician and burial-transit	al Examin	resu
760,	sicié bu	ल	

attending phys the Hospital or Attending Physician: The law requires that the death certificat certificate has be irector, page 2 s director, after death Director: / n 24 hours aft le Funeral Di letely filled in

Division or Vital Records, P.O. Box 68

acility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 940 Bexley Place #512 Marlow Heights Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. ocial Security Number 8. Date of Birth (Month, Day, Year)
Sept. 19, 1924 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 1 ☐ M 2 🖺 F 82 7-26-6698 Washington, DC al Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits ryland Prince George's 1 ☐ Yes 2√No Marlow Heights Street and Number 10f. Zip Code 10g. Citizen of What Country? 940 Bexley Place #512 20746 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Marital Status Black, White, etc 1 ☐ Yes 2 No If Yes, Give Year or Dates: □ Never Married 2 Married Specify: White 1 ☐ Yes 2 XXNo Specify: B ☐ Widowed 4 Moivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ementary/Secondary (0-12) College (1-4or 5+) Waitress Food Service Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Milton L. G. Smith Ellen F. Turner Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) aul Burbage / Son 2900 N. Course Drive #902 Pompano Beach , Florida 33069 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 □Removal from State Cedar Hill Cemetery 06/11/2007 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of uneral Service License 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland at vaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. Part1. Inter the disease, or or implications to shoot, or heart failure. List only one caus Approximate Interval Between Onset and Death nediate Cause (Final ease or condition ulting in death) 4 rout otofrach Ve Due to (or as a consequence of): typing is uentially list conditions, ly, leading to immediate se. Enter Underlying se (Disease or injury initiated events ulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medi IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. β 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) XXYes 2 No ို 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD00 22305 1.5,07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Massoud Nemali MD 3611 Branch Avenue #407 Temple Hills, Maryland 20748 32. Registrar's Signatura 31. Date filed (Month, Day, Yea State

Proctor

3. Time of Death

10:20 A M

Year

June 5, 2007

DHMH 17 Rev 1/2001

Registrar

JUN 0 8 2007

To the within 2

			1 - State Registra Amend#1. PenPhr	State of Mai	-		rtment of H tificate of I		ind Mer	-	jiene leg. No.	· ,	r ionst
	Physicia	an	1. Decedent's Name (First, Middle, L.	ast)						Date of Dea Month	ith Day		3. Time of Death
	/Medic	4	Marie E. Pay 4a. Facility Name (If not institution, gi			Т	4b. City, Town, or	r Location of		lay	_30 4c.	200 County of Dear	
	Examin	ier	Holy Cross H								101		
	Funeral				(In yrs. last b	irthday)	If Under 1 Year	If Under 2	Sprin	Date of Birth)	9. Bir	gomery thplace (State or Foreign
	Director		5/9-20-4916	1 □ M 2 □ M =	87	Yrs.	Months Days	Hours		(Month, Day			ash., DC
pue	>		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Loc	ation						10d. Inside City Limits
Maryl	f sho	ō											1 X Yes 2 No
the	28a- notif	rec	10e. Street and Number	. 1			10f. Zip Code	ashin	gton	1	10g. Citiz	zen of What Co	ountry?
h with	st be	Funeral Director	719 Chaplin	St., SE				20019				Unite	d States
deat	ems 2	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. W	as Decedent of H Yes, specify Cuba	ispanic Orig	gin? (Specify	Yes or No-		14. Race - Ame Black, Whit	erican Indian,
d 6 16 15 15 15 15 15 15 15 15 15 15 15 15 15	it of Health and Mentar Inglene. If it item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	b	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	۲.		□Yes 2l∏No	Specify:	, , , , , , , , , , , , , , , , , , , ,	,,		Specify:	Black
72 hc	natu	Completed	15. Decedent's E (Specify only highest g	Education rade completed)	168	a. Decede	ent's Usual Occup ind of work done of O NOT use retired	ation during most	of working		16b. Kii	nd of Business	/Industry
vithin	han h	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D							
l ed v	ther t	ပ္ပိ	12th 17. Father's Name (First, Middle, Las	(t)			Cle		r's Name (Fi	rst, Middle,	Maiden		rnment
d be	ental ced o	o Be	John Jame	•						rtrud			
should be	mari	P P	19a. Informant's Name/Relationship		19	b. Mailing	Address (Street	and Numbe					Zip Code)
nd 2	alth ag 27 is rrtrau		Bradford L. Pay	ton/Son			1306 Ow						0745
Pages 1 and 2	item item		20a. Method of Disposition		20b. Place o	of Dispos	ition (Name of atory or other place	ce)	Date		20c. Lo	cation - City or	Town, State
- G	ant: if		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		Linco	ln M	emorial	Cem.	6/7/20	07	S	Suitlan	d, MD
permit.	Department Important: I any injury o once.		21. Signature of Puneral Service Lice	TT -		22.	Name and Addre					eral H	
a a c			John 1.	Dewar	ha do ath Da				ing Rd	-		sh., D	C 20019 Approximate
			23a. Part1. Enter the disease, or conshock, or heart failure. List onl					ig, sucii as c	cardiac or re	эрнаюту ап	rest,		Interval Between Onset and Death
	ysician /ledical		Immediate Cause (Final disease or condition resulting in death)	a. Resp1	ratory		Lure						
	aminer			Bilat	eral P		onia						
ă.		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence	e of):							
cuted	nd transil	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	cUrose									
S e ex	urial-l	EX	resulting in death) Last	Due to (or as a	consequence	e of):							
cate	physic the b	edical	•	d									
Sentific C	ding se as	/Me	IF FEMALE:	23c. If yes, outcome p	f pregnancy						1	22d Date of do	lisans
death	e atten	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	☐ Fetal deat		Ectopic pregnancy Other (specify)	/			1	23d. Date of de Month	Day Year
at the	d by the	Phy	9 Unknown			:- Ab a		en in Dart I		02a Did ta			a the serves of death?
The law requires that the death certificate be executed	been signed by the attending physician and should be detached for use as the burial-transit	by	Part II. Other significant conditions	contributing to death but	not resulting	in the und	deriying cause giv	en in Part I.					o the cause of death? robably 4 □Unknown
aw re	s bee 2 sho	Completed								24a. Was a		24b. Were a	utopsy findings available
The	s certificate has b irector, page 2 s	mo									rmed? 2 ፟፟ ☑ No	death?	completion of cause of s 2 □ No
lan:	ertifica ctor, p	Be C	25. Was case referred to medical examiner?					26. Place	of Death (C				
hysic	this ce al dire	To	1 ☐ Yes 2 No	45	t 2 ER/O			4 LI NUI				6 □Other (Spe	ecify)
nding P	After		27. Manner of Death 1 Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day		. Time of Injury	28c. Injur Wor M 1 □	yat k? Yes 2∐N		. Describe h	iow injur	y occurred	
or Atte	after des I Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine			farm, stre	et, factory, office		28f.	Location (S City or Tow			lural Route Number,
To the Hospital or Attending Physician:	within 24 hours after death. To the Funeral Director: \(\) completely filled in by the f	Medical C		Physician: To the best of aminer: On the basis of and manner stat	examination a								
To th	withir To th comp	Me	29b. Signature and title of certifier				29c. Licens	e number		:	29d. Dat	te signed (Mon	th, Day, Year)
			Mary Was	ght re	0			D5610	8			May 31	, 2007
e (2)		30. Name and address of person wif Mary Wright	, M.D. 150	0 Fore	st G	^{Print)} 1en Road	, Sil	ver Sp	ring,	MD	20910	
	Sta		31. Date filed (Month, Day, Year) JUN 0 7 2007	32. Registral	r's Signature	17							
	Registr	al	JUN U 7 2007	Place D.	Upan								

DHMH 17 Rev 1/2001

			For	State of Marylan	d / Depa	artment of H	łealth and M		_	
			State Registrar		Ce	rtificate of	Death	R	leg. No.	1 10953
	E E	71	1. Decedent's Name (First, Middle, La	ist)				2. Date of Dea Month	th Day Yea	3. Time of Death
	Physici /Medic		ELSIE FRANKLIN	PRYOR				June 1,		5:15 p ^M
	Examir		4a. Facility Name (If not institution, given	e street and number)		4b. City, Town, o	r Location of Death		4c. County of De	eath
			3115 Lake Avenu	ie		Chever	lv		Prince	George's
	Funeral		5. Social Security Number 6.			If Under 1 Year Months Days		8. Date of Birth (Month, Day	9. 6	Birthplace (State or Foreign Country)
ш	Director		215-38-6851	1□M 2XF 89	Yrs.	monaic Baye	Tiodio IVIIII	10-20-1		rginia
	pu ,		Usual Residence of Decedent 10a. State 10b. County	100 Cit	y, Town or Lo	antine .				104 1-14- 01-11-1-
	aryla shov d at	<u>.</u>			y, TOWITOI LO	ocation				10d. Inside City Limits 1 X Yes 2 □ No
	8a-f	cto		George's Che	ever1y					
	or 2	Dire	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What	Country?
	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	Funeral Director	3115 Lake Avenue				785		U.S.A.	
	tems	une	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of F If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Al Black, W	nerican Indian, hite, etc.
36	s afte	by F	1 Never Married 2 Married	1 ☐ Yes 2 🕅 No If Yes, Give		1 ☐ Yes 2 💢 No	Specify:		Specify: V	Thite
21215-0036	hour: ural'	d b	3 ☑ Widowed 4 □ Divorced	Year or Dates:	160 Door	dont's Housi Ossur	notion		16h Kind of Busine	(In de cabre
5-		lete	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occup kind of work done	during most of work d)	ring	16b. Kind of Busine Front Roy	•
12	withir	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		cher	u)		Virginia	
	filed within 7 I Hygiene. other than "I ent, the Med		17. Father's Name (First, Middle, Las		100		18. Mother's Name		Maiden Surname)	belloois
au	ould be f Mental I arked of	Be c		•					,	
Ž	hould d Me nark natic	2	Robert Abner Fra 19a. Informant's Name/Relationship		19h Maili	ng Address (Street	Lena Pry		r, City or Town, State	Zin Code)
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.					_				
	1 an Heal em 2 ther		Sandra L. Pryor 20a. Method of Disposition		Place of Dispo	Lake AVE osition (Name of matory or other pla	enue, Cne	Date	lary1and 2 20c. Location - City	
Baltimore,	ages nt of i. If it		1 X Buriat 2 □ Cremation 3 [_Hemovai from State				_ ,	•	
ËΞ	t. Partmen		4 □ Donation 5 □ Other (Special Service of Furieral Service of European Service of Eu			oln_Cemete 2. Name and Addre		5/2007		, Maryland
3ai	permi Depar Impo any ir		21. Signatur of Ednoral Service ace	A ANCOLO			,	T. 4		ltimore Ave.
	₽П = # 0	113	J. Mark Charles	110157			ineral Hor			ille, MD 20781
П			23a. Part1. Enter the disease of conshock, or heart failure. List only	nplications that caused the deat one cause on each line.	n. Do not en	ter the mode of dyl	ng, such as cardiac	or respiratory ari	rest,	Approximate Interval Between Onset and Death
-	Physician		Immediate Cause (Final disease or condition	a. Metastatic	Breast	Cancer				2 Years
1	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):					
15	LAGITITIES		Sequentially list conditions, if any, leading to immediate	b						
	pg iii	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence ot):					
	te be executed ysician and e burial-transit	am	that initiated events resulting in death) Last	C						
760,	e ex		rodding in dodiny Eddi	Due to (or as a conseq	uence or):					
687	ate b hysic the b	lical		▲d						
9	iaw requires that the death certificate as been signed by the attending physic should be detached for use as the	Physician/Medic	IF FEMALE:						1 2 2 2 2	10/11/24
Box	ath ce	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta	Ideath 3	⊒Ectopic pregnanc	у		23d. Date of Month	delivery Day Year
	e deg	sici	1 ☐ Yes 2 █ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	leath 5	Other (specify)			World	Day
P.0	at th	Phy	Part II. Other significant conditions				i- D-+1	00a Did ta	h a a a a u a a a a a a a a a a a a a a	e to the cause of death?
S,	res the	by	Atrial Fabrill		•		en III Fart I.		22	
Records,	equi	ted	Attial Fabilit	acton; sentie	Dement	La		1 D Y	es 2 <u>10</u> 110 3	Probably 4 ☐Unknown
eC	law as be	ple						24a. Was a	sv prior	autopsy findings available to completion of cause of
	The ate he	Completed						perfor 1⊟ Yes	med? death 2∭No 1⊟Y	
or Vital	Physician: The law requires that the de this certificate has been signed by the rail director, page 2 should be detached	Be (25. Was case referred to medical examiner?				26. Place of Deat	h (Check only or	ne)	
2	Physic this co	To	1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3□ DOA Oth	ner: 4 🗆 Nursing Ho	ome 5 X Resid	ence 6 Other (S	pecify)
0 _	ding Pl		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of 28c. Inju Wo	ry at rk?	28d. Describe h	ow injury occurred	
Division	Attending r death. ector: After by the fune	Certification:	2 ☐ Accident investigation	100		M 1	Yes 2 □ No			
Ξ̈́	l or Attend after death Director: /	tific	3 ☐ Suicide 6 ☐ Could not to determined		ome, farm, st	reet, factory, office		28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,
	ital or rs afte ral Dir	Cer					4			
	Hospital 24 hours e Funeral I tely filled	cal		hysician: To the best of my kno miner: On the basis of examina						
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	one)	and manner stated.						
	To To	Σ	29b. Signature and title of certifier			29c. Licens		2	29d. Date signed (Mo	onth, Day, Year)
			I selly y la	elulu		D22	2780		June 4,	2007
0	(I_0)		30. Name and address of person who							
1			Peter M. Schiss			ay Center	Drive, #	430, Gr	eenbelt, N	(D 20770-3542
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ture					
	Regist	rar	JUN 0 7 2007	Talle W. 19						

DHMH 17 Rev 1/2001

			For State	State of M				nt of H		and M	lental Hy	•	2011	7	1 9	•
			Registrar AMFND#8, 9per F	H 6/II/U/,BYW st)	LMCD.	001	imou		Journ		2. Date of De				3. Time of	Death
. *	Physici /Medic		Edwin Terry Proth	iro							June 2	Day 200		ear	2:00	ΡМ
	Examir		4a. Facility Name (If not institution, giv	,			4b. City	, Town, or	Location of				. County of	Death		
		2	8200 Wisconsin Av					iesda		2411			ntgome			
l	Funeral Director		5. Social Security Number 6. S 427–38–8308	TXM 2□F	87	last birthday) Yrs.	Months		If Under Hours	Min.	8. Date of Bir (Moleth Da 12- 12	th ay, Year) 1919	L	orani.	ace (State o Nana Gana	r Foreign
	/land low at		10a. State 10b. County		10c. Cit	y, Town or Lo	cation			14.1		 -		10	d. Inside Ci	ty Limits
	a-f sh ified	ctor	MD Montgor	nery	Bet	thesda									1 🔀 Yes	2□No
	or 28	Director	10e. Street and Number				10f. Zi	p Code				10g. Citi	izen of Wha	at Count	ry?	
	ath w	ral	8200 Wisconsin A					2081					ted Si			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral I	11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent Armed Forces? 1 Tyes 2 X If Yes, Give	•		Was Dece f Yes, spe l □ Yes		spanic Ori n, Mexicar Specify:	gin? (Spe i, Puerto I	ecify Yes or No Rican, etc.))-	14. Race - Black, Specify:	White, e	tc.	
Maryland 21215-0036	hour tural'	ed b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		16a. Deced	lent's lis	al Occupa	ation			165 Ki	ind of Busir	Whi		
7.	nin 72 In "na Medic	Completed	(Specify only highest gra		5.1	(Give life. L	kind of we	ork done d use retired,	luring mos	t of workii	ng	100.10	ind of busin	1635/1/101	usuy	
21,	d with	Com	Liementary/decondary (0-12)	5+	J+ <i>j</i>	Prof	esso	r					Unive	ersi	t y	
nd	be filed ttal Hygi d other event, tl	Be	17. Father's Name (First, Middle, Last,)							(First, Middle	, Maiden	Surname)			
<u>₹</u>	12 should be f h and Mental I r Is marked of raumatic eve	ဍ	Eddie Prothro			T					Terry					
<u>s</u>	id 2 sh Ith and 17 Is n traun		19a. Informant's Name/Relationship (Najla Prothro/ Wi	••							l Route Numb 515, Be					
<u>ഉ</u>	s 1 and 2 f Health item 27 I		20a. Method of Disposition		20b. F	lace of Disportemental Place of Disportemental Place of Disportement Place of Disporteme	sition (Na	me of			ate		ocation - Cit			
Ë	Pages nent of I int: If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			ational				6-8-	2007	Fal	lls Ch	nurci	h,VA	
Baltimore,	permit. Pages Department of Important: If ii any injury or once.		21. Signature of Foreral Service Lic-	see /		22	. Name a	nd Addres	s of Facilit		eph Gaw	ler'	s Sor	is I	nc.	
<u></u>	e a m e	6 9	1 Mesico	Nowsky	•						NW Was		gton,	DC :	20016	
	Physician	8 19	23a. Part1 Éntér the disease, or com shopk, or heart failure. List only Immediate Cause (Final disease or condition	and the second second		h. Do not ente Artery			g, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Bety Onset and D	veen
	/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):										
E	# 20	<u>-</u>	Sequentially list conditions,	b. Due to (or as	a conseq	nence of).										
	uted 1 ansit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	240 10 (01 43	a conseq.	acrice oi).										
,	icate be executed physician and s the burial-transit		that initiated events resulting in death) Last	Due to (or as	a consequ	uence of):										
8/60	ate be nysicia ne bui	dical		d												
٥	ertifica ing ph e as th	Med	IF FEMALE:		-											
O. Box	requires that the death certificate be executed een signed by the attending physician and rould be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 ☐ Feta	Ideath 3	Ectopic p Other (s	regnancy pecify)					23d. Date o Month		,	'ear
7.	that the		Part II. Other significant conditions of	ontributing to death b	ut not resu	ulting in the un	derlying	cause give	n in Part I.		23e. Did to	obacco u	use contribu	ite to the	cause of de	eath?
Hecords,	w requires that been signed b should be deta	d by					, ,				1 🗆				bly 4 □U	
ပ္က	law re as bee 2 sho	Completed									24a. Was		24b. Wei	re autop:	sy findings a	available
	The ate his page	mo:										psy ormed? 2 X No	dea	th?	pletion of ca 2□ No	use of
VITall	Physician: The rhis certificate h	Be	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o					
0	S S	၉	1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatie		ER/Outpatient			4 LI Nui		ne 5🏝 Resid			Specify)		
	ding Phi h. After thi funeral (ion:	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	M	28c. Injury Work	at ? ′es 2⊡n		28d. Describe I	how injur	y occurred			
UIVISION	al or Attending Is after death. Il Director: After din by the funer	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		ury - At ho	me, farm, stre			es ZIII		8f. Location (S			r Rural	Route Numl	ber,
5	tal or s afte al Dir	Certi	4 Homicide	building, et	c. (Specin)	<i>(</i>)					City or Tov	vn, State)			
	the Hospital of the 24 hours at the Funeral Dipletely filled i	edical ((Check only 2 Medical Exam	ysician: To the best niner: On the basis o	of my kno f examina	wledge, death	occurred	at the tim	e, date an	d place, a	and due to the	cause(s)	and manne	er as sta	ted.	1
	To the Hos within 24 ha To the Fur completely	Medi	29b. Signature and title of certifier	and manner sta	ated.			c. License								
)	F 3 F 8	-		11	/	10		Doo 5 7					te signed (A ne 4,2		uy, redi)	
1	15		30. Name and address of person who	completed cause of d	eath (Item	23a) (Type F						5 41.	1,2			
			Eirene Koroulaki					t Ave	e, Ke	nsing	gton,MD	208	395			
þ	Sta Registr		31. Date filed (Month, Day, Year)	32 Registr	ar's Signa	ture	reft 1	ì						_		

		-	For State Registrar	State of	f Marylan		artmen rtificate			ind Me	ental H	ygien Reg. N		7	19966
	Physicia	_	1. Decedent's Name (First, Middle, Las								2. Date of D Month	n	007 Y	эөг	3. Time of Death
	/Medic	al	A. Farith Man (Man Airein Airein)		POSTAL		Ab Cibe	Tour or	Location o		June 4		lc. County of [Death	12:50 A M
	Examin	er	4a. Facility Name (If not institution, give Brighton Gardens	Street and nun	iber)			ockv		Dodui			Mont		ery
Ī	Funeral Director		5. Social Security Number 6. Se	× □ M 2	7. Age (In yrs. 85	last birthday) Yrs.	If Under Months	1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of B (Month, E Sept.	ž8,	^(r) 1921	Birthpl Count New	ace (State or Foreign
	and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10	Od. Inside City Limits
	Maryl	ţō	Maryland Montgome	erv		Rockvi	11e								1 ☐ Yes 2 No
	th the	lrec	10e. Street and Number				10f. Zip					-	Citizen of Wha		·
	ath wi	ral	504 Oak Knoll Ter						850		* \		ted St		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelih and Mental Hydiene. Depertment of Heelih and Mental Hydiene. Inportant: if Item 27 is marked other than "natural", or items 23a or 28a-f show eny highry or other treumatic event, Ite Medical Exactinar must be notified at ADEs.	by Funeral Directo	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Dece Armed For 1 Tyes If Yes, Giv Year or Da	2X No e	1	Was Deced If Yes, spec		spanic Origin, Mexican Specify:	gin? (Spec i, Puerto F	cify Yes or N Rican, etc.)	10-	14. Race - Black, \ Specify:		etc.
9	2 hou	ted	15. Decedent's Ed	ucation			dent's Usua kind of wo			t of workin	0	16b.	Kind of Busin	ess/Ind	lustry
215	ithin 7 16.	Completed	(Specify only highest gra	College (1	-4or 5+)	life.	DO NOT us	se retired,)	OI WOIKE	9		wn Hom	^	
2	led wi lygien her th		12 17. Father's Name (First, Middle, Last)			Hom	emake	r	18. Mothe	r's Name	(First Midd		en Sumame)	.e	
auc	d be fi	To Be	Isaac Shedletsk	y							Posta				
Mary	id 2 shoul	Ė	19a. Informant's Name/Relationship (1 Linda Tebeka, Dau			19b. Maili 504 C	ng Address)ak Kn	(Street a	nd Numbe Terra	or or Rural	Route Num Rockv	ber, City 111e	y or Town, Sta	16, Zip 208	Code) 50
Baltimore, Maryland 21215-0036	Pages 1 ar ent of Hee nt: If Item : ry or other		20a. Method of Disposition		State C	Place of Disponentery, cre Lebar	matory or o	ther place		oa 06/05	ate /07		Location - Cit	-	wn, State
Baltii	permit. Popertm Depertm Importar eny injur		21. Signature of Fur and Service Lices								unera Was		me ton, D	C :	20012
	Physician //Medical Examiner the primaritanult	icai Examiner	23a. Part1. Enter the disease, or compose, or compose, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Ather Due to to Due to to Due to to Due to to Due to to	osclero (or as a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a conseq	uence of): Luence of):				cardiae oi	respiratory	allest,			Approximate Interval Between Onset and Death
P.O. Box 68	law requires that the death certificate be executed es been signed by the attending physicien end 2 should be detached for use as the burtal-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 Live b	come of pregna pirth 2 Teta nant at time of cown	I death 3	⊒Ectopic p ⊒ Other (s _f						23d. Date of Month		ory Day Year
ds, P.	w requires that been signed by should be deta	ρ	Part II. Other significant conditions of	ontributing to d	eath but not res	ulting in the o	anderlying o	ause give	en in Part I					ute to th	ne cause of death?
of Vital Records,	The law rec	Completed									24a. Wh au pe 1 ☐ Yes	topsy rformed	? dea	or to con ath?	psy findings available inpletion of cause of
ita	ian: artifice ctor, p	BeC	25. Was case referred to medical examiner?								(Check onl	y one)			
o of V	To the Hospital or Attending Physician: The I within 24 hours efter death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	은	1 ☐ Yes 2 反 No 27. Manner of Death 1 △ Natural 5 ☐ Pending	28a. Date (Mon	Inpatient 2 ☐ of Injury th, Day Year)	28b. Time of Injury		28c. Injun Worl		2			6 Other		y)
Division	or Attendeter death Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e, Place	of Injury - At h ing, etc. (Speci	ome, farm, si					28f. Location City or 1			or Rura	l Route Number,
_	Hospital 24 hours Funeral letely filled	edical C	29a. Certifier 157 Certifying Pt (Check only 2 Medical Examone)	niner: On the b	e best of my kno asis of examina mer stated.	owledge, dea ation and/or i	th occurred	at the tin	ne, date ar pinion, dea	nd place, a	and due to the	ne cause e, date a	e(s) and mann and place, and	er as st	tated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	11/1	20/1		29	c. Licens	e number				Date signed (
)	17			7/14				D 5	3691			Jι	me 4,	200	7
	10		30. Name and address of person who					otho	ed •	MD '	20817				
			Ajay Reddy, M.I.		egistrar's Sign		u., D	erne.	sua,	7117	~ OO I /				
	Sta Regist		min 0 5 2		MENRI I	K A	284	9							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 28 2007 1:40 pM Charles Eardley Ronald Pereira /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Suburban Hospital Rethesda 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Sri Lanka **Funeral** 6. Sex Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Yea Days Hours 1 ☑ M 2 □ F 4, 1922 Director 84 Nov. <u>212-13-5892</u> Usual Residence of Decedent 10a. State 10c. Cify, Town or Location 10b. County 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12730 Veirs Mill Road, #104 20853 Tanzania Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☒ No Specify Completed by Specify. 3 Widowed 4 Divorced Asian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer Civil Engineering t of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important; If Item 27 is marked any Injury or other traumatic ex ပ Colin Pereira Emily Louise Anghie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12730 Veirs Mill Road, #104, Rockville, MD 20853 Ivy Pereira-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 5/31/07 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Selvice Liven lee 22, Name and Address of Facility
Simple Tribute Funeral and Cremation Center 1040 Rockville Pike, Rockville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate ause (Final Approximate Interval Between Onset and Death as **Physician** disease or condition resulting in death) /Medical Due to r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 4 Unknown 1 🗌 Yes 2 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No cate has by page 2 s perforr this certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 1 TYes 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature 29d. Date signed (Month, Day, Year)

State Registrar

Charles 7 1340

31. Date filed (Month. Day. Year)

8600 Old Georgetown Road, Bethesda, Maryland

cause of death (Item 23a) (Type, Print)

rar's Signature

Division or Vital To the Hospital or Attending Physician: 24 hours after death e Funeral Director; within 24

> State Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

JUN

05

Office Shailesh Sheth, M. D., 32 Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

of Kaiser Hospitalists, Silver Spring, MD

29d. Date signed (Month, Day, Year)

1500 Forest Glen Rd

5/30/2007

29c. License number

52503

07-04428

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Timothy Powell Certificate of Death 1- For State Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day June 9, 2007 Year 1931 hrs Medical Examiner TIMOTHY JAMES POWELL 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Glen Bumie Baltimore Washington Medical Center 9. Birthplace (State or 8. Date of Birth (MM/DD/YYYY) If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Hours Min Months Davs Director 215-02-0990 1X M 2 40 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10b. County 10a State 1 Yes 2 X No 23a or 28a-f show notified at once. MD. CHARLES WALDORF with the Maryland 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 20601 2421 HUNTING LANE 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. Funeral must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) · death v Never Married Married Yes X No BLACK ō Specify: Yes 2 X No specify. f Yes, Give Year Divorced Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Widowed narked other than "natural", event, the Medical Examiner ò 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) CONSTRUCTION CO CONCRETE FINISHER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LORETTA WILLIAMS 2121 JAMES EDWARD POWELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 27 is I 2 20601 WALDORF, MD 2514 LISA DR LORETTA WILLIAMS-MOTHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition 3altimore, crematory or other place) t: If it Xaurial 2 Cremation 3 Removal from State Crem 6-15-07 WALDORF, MD. MEM.GARDENS Other Specify Donation 5 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A.

I.A. PIATA MD. 20646

Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 21. Signature of Funeral Service Licensee MOO:479 Approximate Interval Between Onset and **Physician** failure. List only one cause on each line Death /Medical a. Head Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit hysician/Medical UNPENDED AMENDED ysician burial -Hospital or Attending Physician: The law requires that the death certificate be Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy tending phys IF FEMALE: Month Day Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 靣 P.O. Yes 2 No 3 Probably 4 Unknown 2 Completed 24b. Were autopsy findings available Division of Vital Records, 24a. Was an has been prior to completion of cause of autopsy death? performed? 1 🗸 Yes Yes 2 No раде certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Other Hospital: 1 examiner? Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 this 1 V Yes No 28a. Date of Injury (Month_Day,Year) 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury After 27. Manner of Death Driver auto fixed object collision Jun 9, 2007 1844 hrs Yes 2 V No Natural neral Director: Pending 24 hours after death. Certificati 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 2642 Capitol Raceway Road , Odenton , MD 3 Suicide (Specify) raceway To the Funeral completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 10, 2007 O.C.M.E. 001 30. Name and address of person who completed cause of death (Item 23a) To 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Tasha Greenberg MD.

State

Registrar

31. Date filed (Month)

ORIGINAL

Registrar's Signature

Charles and a

2007

OCME

			1 - For State of Maryland / Depa	rtment of Heal	a+b	giene
	Physici: /Medic	an	1. Decedent's Name (First, Middle, Last) MIRIAM ROTHOUBERG		2. Date of Dea Month	ath Day Year 12 40 N
į.	Examin		4a. Facility Name (If not institution, give street and number) Montgomery General	4b. City, Town, or Loca Olney	ation of Death	4c. County of Death Montgomery
	Funeral Director		5. Social Security Number 286-10-1145		Jnder 24 Hrs. 8. Date of Birth ours Min. 9/24/16	9. Birthplace (State or Foreign Country)
	th the Maryland or 28a-f show e notified at	Director	Usual Residence of Decedent	Spring 10f. Zip Code		10d. Inside City Limit ↑★□Yes 2□N 10g. Citizen of What Country?
2-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married		nic Origin? (Specify Yes or No- lexican, Puerto Rican, etc.)	US 14. Race - American Indian, Black, White, etc. Specify: White
7 7	ed within 72 ho ygiene. er than "natu	Be Completed	(Specify only highest grade completed) (Give kind Differentiary/Secondary (0-12) College (1-4or 5+)	ent's Usual Occupation kind of work done during OO NOT use retired) emaker	g most of working	16b. Kind of Business/Industry Own Home
ryland	d tal	To Be	17. Father's Name (First, Middle, Last) Sam White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing		Mother's Name (First, Middle, Ida "Unkno	11
e, Ma	.1 and 2 sho Health and tem 27 is mi		Joan Weinberg-Daughter 15128 20a. Method of Disposition 20b. Place of Dispos	Middlegat		Spring, Md. 20905
Банттог	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any Injury or other traumatic. once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22.	natory or other place) morial Gard . Name and Address of	Facility	Olney, Md.
ă	Dep Imp		23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.			rest, Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):		Q.T	Onset and Death
09/00,	rate be executed by yesician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. The Charles of the accessory of the conference of t	LOTTERY	ATHY.	+SE
O. BOX 6	requires that the death certificate een signed by the attending phys hould be detached for use as the	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
coras, P.	w requires that s been signed by should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the unit DIABETES MELLITUS	derlying cause given in	Part I. 23e. Did to	obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknow
T T	The law ate has b page 2 sl	Completed	DEMENTIA, HUPOTRUPO	DISM:	1	prior to completion of cause of death? 2 \(\begin{align*} \text{No} & 1 \text{Yes} & 2 \text{No} \end{align*} \)
DIVISION OF VITAL	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification: To Be	25. Was case referred to medical examiner? 1	t 3 DOA Other: 4 28c. Injury at Work? 1 Yes	2 □ No	dence 6 □Other (Specify) now injury occurred Street and Number or Rural Route Number,
2	e Hospital of 24 hours all e Funeral E	edical Cer	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death and manner stated.	occurred at the time, d	date and place, and due to the on, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
)	To the I	Me	29b. Signature and title of pertifier M.D.	29c. License nun	5024	29d. Date signed (<i>Month</i> , <i>Day</i> , <i>Year</i>)
	V		30. Name and address of person who completed cause of death (Item 23a) (Type, F	M C-LI	18101 Prince I	Philip Drive

State Registrar 31. Date filed (Month, Day, Year) JUN 05 2007



DHMH 17 Rev 1/2001

Olney, MD

			For Stete Registrar	State of Mary		artment of Heartificate of De			ene	19965
	Physici		Decedent's Name (First, Middle, Last) ROBERT	BISHOP	RO:	56		2. Date of Death Month JUNE 1	Day Yea 2007	3. Time of Death 2:15 P M
	/Medic Examin		4a. Facility Name (If not institution, give str ROCKVILLE NURSING	eet and number)	NO	4b. City, Town, or Loc ROCKVIL	cation of Death	JUNE 1	4c. County of De	
	Funeral Director		5. Social Security Number 6. Sex 1279-40-1774		n yrs. last birthday) 74 Yrs.		lours Min.	8. Date of Birth (Month, Day, Feb. 22	9. B 1933	irthplace (State or Foreign Country) Illinois
	faryland show	or	Usual Residence of Decedent 10a. State 10b. County Md • Montgome		oc. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the A 3a or 28a-1	Funeral Director	10e. Street and Number 1030 Hawlings Road			10f. Zip Code	20833	10	g. Citizen of What (
980	be filed within 72 hours after death with the Maryland tal Hygiene. id other than "natural", or items 23a or 28a-f show event, the Madical Examination at the modified at	by	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Eve Armed Forces? 1. ☑ Yes 2 ☐ No If Yes, Give Year or Dates: KO		Was Decedent of Hispa If Yes, specify Cuban, N 1 Yes 2 No S	nic Origin? (Spe Mexican, Puerto F pecify:	cify Yes or No- Rican, etc.)	Black, Wi	nerican Indian, nite, etc. White
21215-0036	d within 72 ho giene. rr than "natur irre Modical	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) 12	tion completed) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during DO NOT use retired)	ng most of workin	g	6b. Kind of Busines Law Enfo	·
Maryland	2 should be filed within n and Mental Hygiene. 'is marked other than reumetic event, the Ma	To Be C	17. Father's Name (First, Middle, Last) Robert B. Ross	145-		18.	Mother's Name Harriet	(First, Middle, Mi Smart		
	s 1 and 2 should if Health and Men item 27 is marke other treumetic		19a. Informant's Name/Relationship (Type Constance R. Blain			ng Address <i>(Street and a</i> 30 Hawlings			-	. Zip Code) 20833
altimore,	Page nent o ant: If ary or		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rei '4 ☐ Donation 5 ☐ Other (Specify)			sition (Name of matory or other place) Cemetery	6/6		Oc. Location - City of Brookevi	
Balt	permit. Departr Imports any inji		21. Signature of Funeral Service Licensee	Back	ev		Barber : 5038,	Laytonsv	<u>ille, Md</u>	
	Pnysician		23a. Pant 1. Enter the disease, or complications shock, or heart failure. List only one Immediate Cause (Final disease or condition a.	cause on each line.	o death. Do not ent		uch as cardiac or	respiratory arres	st,	Approximate Interval Between Onset and Death
8760,	/Medical Examiner physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	NAL FAILU onsequence of):	RE				
.O. Box 68	The law requires that the death certificate be executed tte has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	: If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year
0	quires that t in signed by uld be deta	þ	Part II. Dther significent conditions conti	buting to death but n	ot resulting in the u	nderlying cause given ir	n Part I.			to the cause of death? Probably 4 SUnknown
I Records,		Completed						24a. Was an autopsy perform	ed? prior t death	autopsy findings available o completion of cause of ? es 2 □ No
Vital	icien: certific rector.	Be	25. Was case referred to medical examiner?	spital:	0F15B/0			(Check only one		
of	ding Fune	atlon: To	1 Yes 2 XNo 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yo	2 ☐ ER/Outpatier 28b. Time o Injury	f 28c. Injury at Work?		8d. Describe how	ice 6 □Other (S) v injury occurred	pecity)
Division	i Pitto	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, sti Specify)	reet, factory, office	2	8f. Location (Stre City or Town,		Rural Route Number,
	To the Hospitel within 24 hours and the Funeral Completely filled	edical (amination and/or in	h occurred at the time, ovestigation, in my opinion				
	To the within 2 To the complet	M	29b. Signature and title of certifier	Run	M	29c. License nu	umber 06462		d. Date signed (Mo	onth, Day, Year) 94, 2007
7 (,		30. Name and address of person who com SANDEEP SHARMA, M.			Print) ECTICUT AVI	E., #100	, KENSIN	IGTON, MD	. 20895
	Sta Registi	-	31. Date filed (Month, Day, Year) JUN 0 5 200	32. Hegistrar's	Signature	melle				

Baltimore, Maryland 21215-0036		/sic ledi ami
VITAL RECORDS, P.O. BOX 68/60,	siclan: The law requires that the death certificate be executed	certificate has been signed by the attending physician and

	1	For State of N Registrar	aryland / De		it of Health e of Death			giene Reg. No.	200	7 19966	
hysician /Medical		I. Decedent's Name (First, Middle, Last) Aaron ROSENSTADT					ath Day 20	07	3. Time of Death		
miner ral		Montgomery General Hospital 5. Social Security Number 218 -22 -8234 6. Sex 1		(ay) If Unde	4b. City, Town, or Location of Death Olney If Under 1 Year If Under 24 Hrs. Months Days Hours Min.				ntgome 9.8		
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits										
al Directo	\vdash	10e. Street and Number 3210 N. Leisure World Blvd.,		10f. Zip Code			10g. Citizen of What Country? United States				
by Funeral		11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married X 3 □ Widowed 4 □ Divorced 12. Was Deceder Armed Forces 1 □ ¬ Les 1f Yes, Give Year or Dates	INo X	13. Was Dece If Yes, spe 1 ☐ Yes	dent of Hispanic C cify Cuban, Mexic 21. No Specify		ify Yes or No ican, etc.)		Black, Wi	nerican Indian, nite, etc. white	
Completed		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4o 5+	r 5+)	ecedent's Usu Give kind of wo fe. DO NOT u	·	ost of working	g		nd of Busines		
To Be Co		17. Father's Name (<i>First, Middle, Last</i>) Nathan Rosenstadt			1	18. Mother's Name (First, Middle, Maiden Surname) Gertrude Klavansky					
once. To Be Completed by Funeral Director		19a. Informant's Name/Relationship (Type. Print) Anita Rosenstadt, Wife 20a. Method of Disposition 1	321 20b. Place of D cemetery,	O N. I	me of	orld B	Blvd.,	#516	, Silv	ver Spring, MI	
once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral pervice Licensee	5000000	Torchi	nd Address of Fac nsky Heb rroll St	rew Fu	meral	Home		20012	
edical Examiner	23a. Part Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
Physician/Me		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1					23d. Date of delivery Month Day Ye			·	
ted by Ph		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in					23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unkno				
Completed							perfo 1□ Yes	utopsy prior to completion of cause of death? ss 2 ☑ No 1 ☐ Yes 2 ☐ No			
Medical Certification: To Be Completed by Physician/Me	25. Was case referred to medical examiner? 1										
		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
Mec		29b. Signature and title of complier 30. Name and address of person who completed cause of death (Item 23a) (Type,			29c. License number 3C (682639			June 1, 2007			
State gistrar		Matthew Connolly, M.D., 1			ip Dr.,	#225 ,	Olney,	MD	20832	2	

DHMH 17 Rev 1/2001

State Registrar Wolfestreet Baltimore, Maryland 2128

May 30, 2007

, Janice Leung, Medical Doctor

32. Aegištrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

31. Date filed (Month, Day, Year)

JUN

05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#24a, per VERB, G868, 6/19/07 WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 5:55 P Bobbie Geneva Russel /Medical June 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 💢 F **Director** 246-48-5203 01/17/1932 North Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Frederick Brunswick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21716 United States 812 6th Avenue Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Farmers & Mechanics College (1-4or 5+) Elementary/Secondary (0-12) National Bank <u>Bank Teller</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٥ <u>Gordon Barnes</u> <u>Ella Mae Evans</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Scott A. Russel/Son <u>812 6th Avenue, Brunswick, Maryland 21716</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematorium 6/12/2007 Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jefferson Chapel Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death

2 Immediate Cause (Final disease or condition resulting in death) neamonia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or defining Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: within 24 hours after death.

To the Funeral Director: After (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Branswick MD 21716 5 nland 610 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 9 2007 Registrar

			State of Maryland / Department of State State Of Maryland / Department of Certificate of Certif				-	007	12070
			1. Decedent's Name (First, Middle, Last)	Death		. Date of Dea		1	3. Time of Death
	Physicia		Roberta S. Strand			Month June 4	Day 2007	Year	11:45P M
	/Medic Examin	-	4a. Facility Name (If not institution, give street and number) 4b. City, Town,	, or Location				nty of Death	110 131
			Casey House Rockvil				Mont	gomery	У
Say.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea Months Day:		Min.	. Date of Birth (Month, Day	, Year)	Coul	place (State or Foreign ntry)
М	Director	-	4/8-16-1921		S	ept 27	, 1919	Iowa	
	and t	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location						10d. Inside City Limits
	Mary f sho ied a	호	MD Montgomery Rockville						1 ☐ Yes 2 📉 No
	r 28a	iec	10e. Street and Number 10f. Zip Code	9		1	10g. Citizen o	of What Cou	ntry?
	h with	a D	13511 Crispin Way 20853			Ţ	USA		
	ems a	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of If Yes, specify Co.	f Hispanic Or uban, Mexica	rigin? (Speci	fy Yes or No- can, etc.)	14. F	lace - Americal	
õ	or its		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No				Spe	cify:	
212-0036	e filed within 72 hours after death with the Maryland al Hygiene. other than "natural", or items 23a or 28a-f show vent, <u>the Medical Examiner must be notified</u> at	bd by	3 ☑ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occ	runation			16b. Kind of	Whit Business/Ir	
<u>ဂ</u>	in 72 "na" r	Completed	(Specify only highest grade completed) (Give kind of work don life. DO NOT use reti	ne during mo:	st of working	'			,
7	iene. iene. r thar	E	Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher	`			Educa	tion	
פ	other vent,	Be C	17. Father's Name (First, Middle, Last)	18. Moth	ner's Name (First, Middle,	Maiden Surr	ame)	
yland	uld be Menta rrked rilc ev	10 E	Chas Chester Shoemaker	Ida	Ruth S	Smith			
Mary	2 sho and l is ma auma		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Stre						p Code)
2 (€	and lealth m 27 her tr		Sharon D. Strand/daughter 13511 Crispin		ROCKV.		20c. Locatio		Town State
<u> </u>	iges 1 nt of F if ite or ot		20a. Method of Disposition 1 ☐ Burial 2XICremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other p	1				•	
Baitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify) Chesapeake Crema: 21. Signature Funeral Service Licenses / / / 22. Name and Ado			/0/ []	Beltsv	ıııe,	MD
g	perm Depa Impo any I	8 9	Going Home	e Crem	nation				
п			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of d shock, or heart failure. List only one cause on each line.	Jying, such a	as cardiac or	respiratory ar	rest,	SVILLE	Approximate Interval Between
	Physician	0.14	Immediate Cause (Final						Onset and Death
	/Medical		disease or condition resulting in death) Intra abdominal infection Due to (or as a consequence of):						-
	Examiner		Sequentially list conditions						
	Po ti	Examiner	Sequentially list conditions, if any, leading to immediate guess. Enter Underlying						
	ecute and I-trans	xam	Cause (Disease or injury that initiated events c						
8760,	icate be executed physician and s the burial-transit	alE							
2		edical	d						
ROX	it the death certif by the attending tached for use as	N/N	IF FEMALE: 23c. If yes, outcome pf pregnancy				23d.	Date of deliv	very
	death e atte	icia	in the past 12 months? 1 Vas 2V No. 4 Pregnant at time of death 5 Other (specify)					Month	Day Year
J.	at the by th tache	Physician/Me	9 □ Unknown			T			
	The law requires that the tte has been signed by the bage 2 should be detache	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part	t I.				the cause of death?
Vital Records,	w requires been signe should be					'''	res Z) 3[] FIC	Dably 42 Officiowii
Se C	e 2 st	Completed				24a. Was		tb. Were aut prior to co death?	topsy findings available completion of cause of
ᇤ						1□ Yes	2 XNo		2□ No
<u> </u>	siciar certif rector	Be	25. Was case referred to medical examiner? 1 Yes No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other		(Check only o		011 (2	" hogpioo
ō	Physer this eral di	5		nĵury at Nork?		Bd. Describe h			oify) hospice
on	th. : Afte	tion		Work? 1 ∐ Yes 2 [□No				
Division or	Atter	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	ce	28	Bf. Location (S City or Tox	Street and Nu	ımber or Ru	ral Route Number,
	tal or s afte al Dir ed in	Certification:	- Committee of the comm						N.
	To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director; After this certifica completely filled in by the funeral director, I		29a. Certifier (Check only (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in m	e time, date a ny opinion, d	and place, ar leath occurre	nd due to the d at the time,	cause(s) and date and pla	manner as ce, and due	stated. to the cause(s)
	othe ithin 2 othe	Medical	one) and manner stated. 29b. Signature and title of certifier 29c. Lice	ense number	r		29d. Date si	gned (Month	h, Day, Year)
1	FXF8		Dhenere (1) rollow Sto m) D646.	15			June 5		
	\sim \circ		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1.)			June 3	2007	
(1	2)00		Genevieve Wroblewski, M.D. 1355 Piccard Dr. 1	Rockvi	11e, N	MD 2085	50		
	Sta	nte	31. Date filed (Month, Day, Year) 32. Tegistrar's Signature						
	Regist	rar	JUN 0 7 2007 Stewn & Soule						

According Foundation Foun				1 - For State of Maryl.		artment of F			ene g. No	07	19971
Mark R. Shockley Familiar Familiar Function		Physic	20	1. Decedent's Name (First, Middle, Last)						Year	3. Time of Death
Continued Cont				Mark H. Shockley				_			1:30 A M
Second Secretary Number Second Directory Second Secretary Number Second Secretary Number Second Secretary Number Second Secretary Number Second Second Second Secretary Number Second	}			4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location of Deat	h			
221-12-5199 TOW 32 84			74 3						Ceci	1	
10.5 State 10.5 Color 10.	30			221-12-5199 ¹\\\X\ ^M 2□F 8				(Month, Day,	^{Year)} 1922	Coun	try)
The property of the property o	6	how			City, Town or Lo	ocation				1	0d. Inside City Limits
Thursday Thursd	4	28a-f s	ecto		<u>F</u>			10	Or Citizen of	What Cour	1 X Yes 2 □ No
The property of the property o	4	Se or	۵				21921		-		
Thursday Thursd	4	ms 23	era	11 Marital Status 12. Was Decedent Ever i	n U.S. 13.			pecify Yes or No-			an Indian.
Tritumore Trit	036	at', or Iter		1 ☐ Never Married 2 ☐ Married 1 ☐ XYes 2 ☐ No				o Rican, etc.)		hv-	
The property of the property o	2	natur	eted	15. Decedent's Education (Specify only highest grade completed)				rking 1	6b. Kind of B		
Physician Medical Examiner Physician Medical Examiner Physician Medical Examiner Physician Medical Examiner Teauling in death Teauling in dea	121	than the Me	ompi	Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retire	d)	g	D111m	hina	
Physician Medical Examiner Texturing in death) Texturing a death of the disease, or complication final caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest. Immediate Joseph Final Joseph Fin	ט פ	Hyg other			110	IMDEL	18. Mother's Na	ne (First, Middle, M			
Physician Medical Examiner Texturing in death) Texturing a death of the disease, or complication final caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest. Immediate Joseph Final Joseph Fin	/lan	Menta Menta nrked ntic ev	ToB	Grover Cleveland Shockley			Marga	aret Virg	inia W	arrin	gton
Physician Medical Examiner Texturing in death) Texturing a death of the disease, or complication final caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest. Immediate Joseph Final Joseph Fin	lan,	is ma				-					Code)
Physician Medical Examiner Texturing in death) Texturing a death of the disease, or complication final caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest. Immediate Joseph Final Joseph Fin	e ;	Health Im 27 Iher t			the second secon						- Chata
Physician Medical Examiner Texturing in death) Texturing a death of the disease, or complication final caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest. Immediate Joseph Final Joseph Fin	o a	in Tite		I Donal 2420 dell'according a Direction 2/2/2							
Physician Medical Examiner Texturing in death) Texturing a death of the disease, or complication final caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest. Immediate Joseph Final Joseph Fin		artme ortani Injury						P.A. R	ısıng	Sun,	Maryland
Physician Medical Examinor Top Care State Class (Final failure. List only one cares on each line. Class (Final failure. List one class on each line. Class (Final failure. List one class on each line. Class one care on each line. Class one class on each line. Class one class one	8 8	De Contraction of the Contractio		Kichard L. Coolie	R	R. T. Foa	rd Funera	al Home, et, Risin	P.A. g Sun,	MD 2	1911
Due to (or as a consequence of): Due to (or as a consequence of):		/Medical	er	shock or heart failure. List only one car se on each line. Immedial Cause (Final disease or condition resulting in death) a Due to (or as a condition for the condition of the conditi	SI sequence of): STAL	11121		c or respiratory arre	St,		
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 2 North, Day Year) 28a. Date of Injury 3 North, Day Year) 28b. Time of Injury 4 North, Day Year) 28c. Injury at Work? 3 North, Day Year) 28d. Describe how injury occurred 28d. Desc	1 68 / 60,	ng physicien and	Medical Examin	resulting in death) Last C. Due to (or as a con-	sequence of):						
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 2 North, Day Year) 28a. Date of Injury 3 North, Day Year) 28b. Time of Injury 4 North, Day Year) 28c. Injury at Work? 3 North, Day Year) 28d. Describe how injury occurred 28d. Desc	CO. BOY	by the ettendi	hysician/I	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome of pre 1 Live birth 2 Pregnant at time of	etal death 3		у				•
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 28. Place of Injury Month, Day Year) 28. Place of Injury Month, Day Year 28. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Injury Month, Day Year 28. Place of Injury Month, Day Year 28. Place of Injury Month, Day Year 28. Place of Injury Month, Day Year 28. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Injury Month, Day Year 28. Place of Injury Month, Day Year 28. Place of Injury Month, Day Year 28. Place of Injury Month, Day Year 28. Place of Injury Month, Day Year 28. Place of Injury Month, Day Year 28. Place of Injury Month, Day Year 28. Place of Injury Month, Day Near 28. Place of Injury Month Month Month Month Mo	ords, F	en signed en signed buld be del	<u>م</u>	Part II. Other significant conditions contributing to death but not	resulting in the u	inderlying cause giv	ven in Part I,				
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of pertifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Accept State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	al Hecc	icete hes be r, page 2 sh						autopsy perform	ed?	prior to con death?	npletion of cause of
29a. Certifier (Check only one) 29b. Signature and title of pertifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arien Stokes 31. Date filed (Month, Day, Year) 32. Registrar's Signature	7	centi	8	examiner?		Ott	or A				
29a. Certifier (Check only one) 29b. Signature and title of pertifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arien Stokes 31. Date filed (Month, Day, Year) 32. Registrar's Signature	o	r this		1 Tes 2 No 1 Inpatient 2		nt 3 DQA	4 Nursing F				"
29a. Certifier (Check only one) 29b. Signature and title of pertifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arien Stokes 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Ou	th: : Afte	tlor	1 Natural 5 Pending Month, Day Year) Injury	Wo	rk? Yes Z□No		,,		
2+ IVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARIEN STOKE IN BIT (THRECHMAN) CT2 NEW CASTLE DE 19711 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	DIVIS	after dea Director	ertifica	3 Suicide 6 Could not be 28e. Place of Injury - A	it home, farm, str ecify)					ber or Rura	l Route Number,
2+ IVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARIEN STOKE IN BIT (THRECHMAN) CT2 NEW CASTLE DE 19711 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	e Hospita	n 24 hours		(Check only 2 Medical Examiner: An the basis of exam	knowledge, death nination and/or in	h occurred at the tirvestigation, in my o	me, date and place opinion, death occu	a, and due to the cal arred at the time, da	use(s) and m te and place,	anner as st and due to	ated. the cause(s)
2+ IVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARLEN STOKE MS BI7 (TARCHMAN) C72 NEW CASILE DE 19711 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Ţ	To the comp	Me	29b. Signature and title of gettilier				29	d. Date signe	ed (Month, I	Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARUST STONE M BIT (ITW2CHMAN) 172 NEW CHETCE DE 19711 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature				· ///		D54	0/3	1	74 Jun	107	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	2	+ IVA		A C 1 0.0 cm			NEWGIS				
Registrar JUN 7 2007 Kiloma & Market				740001 51000							

			1 - For State Registrar	State of Maryla		artment of H			iene	7 19872
	Physici /Medic	al	1. Decedent's Name (First, Middle, Las Charles Alf	red Sew	ard:	Sr.		2. Date of Death Month	Day 6 - Ye	3. Time of Death 945 AM
	Examin Funeral Director	er	4a. Facility Name (If not institution, give Chester River 5. Social Security Number 219–05–8820	Hospital Co	enter s. last birthday) Yrs.	the City, Town, or Chester If Under 1 Year Months Days	town, If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, FEB. 14		
	the Maryland 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD QUEEN A 10e. Street and Number	10c. (CENTRE	VILLE				10d. Inside City Limits 1 ☐ Yes 2 X No
	eth with s 23a or		225 WHITE MARSH I			10f. Zip Code 2161	7		USA	-
21215-0036	4 within 72 hours after deeth with the Maryland Jiene. I the Madical Examiner must be nutillisd at the Madical Examiner must be nutillisd at	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest grad	de completed)	2-1945	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ▼ No dent's Usual Occupa kind of work done of DO NOT use retired	n, Mexican, Puerto Specify: ation	Rican, etc.)		American Indian, White, etc. WHITE ess/Industry
d 212	77 75 5 44		Elementary/Secondary (0-12) 5 17. Father's Name (First, Middle, Last)	College (1-4or 5+) -0-		EMAN	18. Mother's Name		ROAD DI	NE COUNTY EPT.
Maryland	lid be fental rked o	To Be	JOHN FRANKLIN	SEWARD				ENCE REBI		VENGER
	nd 2 shou aith and N 27 is main ir traumain		19a. Informant's Name/Relationship (7 IRENE RAMONA SEWA			ng Address <i>(Street a</i> WHITE MAR				
Baltimore,	00		20a. Method of Disposition 1	Removal from State	Place of Dispo cemetery, crei	esition (Name of matory or other place LELD CEME)	e)	Date 2	ENTREVIL	or Town, State
Balt	permit. Pag Department Important: I sny injury o once.		21. Signature of Funeral Service Licen	elfentra	FE 40	8 S. LIBE	FENBEIN &	CENTREV	ILLE. MD.	HOME, P.A.
	Physician /Medical Examiner	.	23a. Parf1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Due to (or as a consi	stat. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Ogsehand Death
68760,	death certificate be executed e ettending physicien and of for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect. Due to (or as a consect.						
O. Box	that the death certific led by the ettending p detached for use as t	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
Ω,	w requires that the s been signed by th should be detache		Part II. Other significant conditions co	ntributing to death but not re	esulting in the u	nderlying cause give	on in Part I.			te to the cause of death? Probably 4 □Unknown
Vital Records,	> 0 0	e Completed by	25. Was case reterred to medical					110	Prior deat	e autopsy findings available to completion of cause of h? Yes DNo
o	To the Hospitel or Attending Physicien: The law within 24 burus after death. yithin 24 burus after death. your Funerel Director: The this certificate hes completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2.	ToB	examiner?	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	⊒ ER/Outpatier 28b. Time o Injury	28c. Injury Work	Pr. 4 ☐ Nursing Ho	me 5 ☐ Resider 28d. Describe how	nce 6 Other (Specify)
Divisi	tel or Atter s after dea el Director ed in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)		17	28f. Location (Str. City or Town,	eet and Number o State)	r Rural Route Number,
	o the Hospitel ithin 24 hours of the Funerel ompletely filled	edlcal (29a. Certifier 1 Certifying Phyone) 2 Medical Example	sicien: To the best of my kiner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the tim vestigation, in my op	e, date and place, pinion, death occurr	and due to the ca ed at the time, da	use(s) and manne te and place, and	or as stated. due to the cause(s)
1	To the To the Complet	M	295. Signature and title of certifier	2 m		29c. License	05 X		d. Date signed (M	つ
0		7.1	30. Name and address of person who co	ompleted cause of death (It	em 23a) (Type,	Print) SPE	en ch	ESTENO	nno	2/627
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 8	32. Registrar's Sig	nature	hart :				

		1 = State Registrar 1. Decedent's Name (First, Middle, La			partment of ertificate of			Reg. No.	97	3. Time of Death
Physicia /Medic		Karen		Sieg			Month June	Day 5	Year 2007	2:55 a _M
Examin Funeral	er	4a. Facility Name (If not institution, giv 10725 Lady S1; 5. Social Security Number 6. S	pper Terrace	e (In yrs. last birthde 59 Yrs.	Nortl Nortl If Under 1 Year Months Days	n Bethesda If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ay, Year)	gomery 9. Birthpl Count	lace (State or Foreign try)
Director		265-84-5375 Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or			December	28,1947		Od. Inside City Limits
28a-f sk	Director	Maryland Montgome 10e. Street and Number	ery		North Bethe	sda		10g. Citizen of V	Vhat Court	1 □Yes 2X No
23a or ust be		10725 Lady Sli	pper Terrace		101. ZIP 0000	20852			U.S.A.	•
al", or items Examiner m	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	Ever in U.S. 1:	3. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No		pecify Yes or No to Rican, etc.)	14. Rac Blac Specify	e - America k, White, e	
if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	(Gi	cedent's Usual Occu ive kind of work done b. DO NOT use retire Attorne	during most of wo	rking	16b. Kind of Bu		
and mental riverse. Is marked other than aumatic event, th∍ Me	Be Co	17. Father's Name (First, Middle, Last,		<u> </u>	Actorney	1	me (First, Middle,	, Maiden Surnan		ent
narked	2	Arthur Ka				1	lorence Ma			
27 Is n r traun		19a. Informant's Name/Relationship (Mark Siegel - Hu			ailing Address <i>(Stree</i> 25 Lady Sli j					,
Department of Health Important: If Item 27 I any Injury or other tra		20a. Method of Disposition 1 Substituting Burial 2 Cremation 3 4 Donation 5 Other (Specification)	Removal from State	20b. Place of Dis cemetery, c	sposition (Name of rematory or other plane) Remembrance	ace)	Date /2007	20c. Location -	City or To	
Importa any Inju		21. Signature of Funeral Service Ucer	nsee		22. Name and Addr Hines-Rinald 11800 New Ha	ess of Facility	Home, Inc.			
ysician Medical aminer		23a Part1. Enter the disease, or com shock, I'r heart failure. List only Immedia e Cause (Final disease or condition resulting in death)	a. Astro	the death. Do not ene. cytoma a consequence of):	enter the mode of dy	ing, such as cardia	c or respiratory a	rrest,	5	Approximate Interval Between Onset and Death years
physiclan and the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Underlying Cause) that initiated events resulting in death) Last	c	a consequence of): a consequence of):						
certificate has been signed by the attending prector, page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ⊟Ectopic pregnan 5 Other (specify)	су			te of delive	ry Day Year
en signea u	þ	Part II. Other significant conditions of	contributing to death bu	ut not resulting in the	underlying cause g	ven in Part I.		obacco use cont Yes 2 No		ne cause of death? ably 4 ≴ Unknown
cate has be page 2 sho	Completed							psy ormed?	prior to con death?	psy findings available inpletion of cause of
s certifi firector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital:	nt 2□ER/Outpat	ient 3 DOA OI	la a u	ath (Check only o	one) dence 6 □Oth	or (Cassite	d
To the Funeral Director: After this certificate he completely filled in by the funeral director, page		27. Manner of Death 1 ★Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Da)	ry 28b. Time	e of 28c. Inju			how injury occur		//
ral Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inju- building, etc	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (: City or Tou	Street and Numb wn, State)	er or Rurai	l Route Number,
he Fune	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ay sician: To the best on the basis of and manner sta	examination and/or	eath occurred at the investigation, in my	ime, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place,	anner as st and due to	ated. the cause(s)
	Me	29b. Signature and title of certifier				se number		29d. Date signer		Day, Year)
3		30. Name and address of person who			e, Print)	065214		June 5,		
Sta	to	Lisa Houde McGrail 31. Date filed (Month, Day, Year)		ar's Signature	Avenue, Suit	e 1300, Che	evy Chase,	Maryland	20815	

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** 3:30 ^{a м} Mary Saur Louis June 2007 2 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Brighton Gardens, Bethesda Rockville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2013 F Director Nov. 12, 579-90-9805 88 1918 Florida Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d, Inside City Limits 28a-f show notified at 1 □Yes 2 RNo Director Maryland Montgomery Kensington the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ō Examiner must be or Items 23a 4316 Puller Drive 20895 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: SpecifWhite à 3 Widowed 4 Divorced 'natural" Completed 16a. Decedent's Usual Occupation Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the Homemaker Own Home traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Allen Smith Mary Esther Hinson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health Judith A. Pointer/Daughter 4316 Puller Drive, Kensington, Maryland 20895 other t altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages June ortant: If it Injury or o 1 → Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2007 Silver Spring, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility ins Funeral Home Inc. Collins 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrest /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter uncertying Cause (Disease or injury that initiated events resulting in death) Last Coronary Artery Disease Due to (or as a consequence of): Examine death certificate be executed burial-trans Congestive Heart Failure and Due to (or as a consequence of): attending physician Box 68760 Physician/Medical Cerebrovascular Accident the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖪 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the detached 9□Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ 1 Yes XXNo 3 Probably 4 Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 1 Yes 2 No Division or Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1x Natural 5 Pending • Hospital or Au.
• nous after death.
• Director: AF 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a **XCentrying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 9 29b. Signature and title of cert D53691 June 5, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ajay Reddy, M.D. 6320 Democracy Blvd., Bethesda, MD 20814 31. Date filed (Month, Day, Year 32. Segistrar's Signature State 0 JUN 6

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 2007 Ethel L. Snowden June 2134 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince George's Clinton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 M 2 X F Yrs. Director 579-44-8507 96 June 12, 1910 Tennessee Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Directo Maryland | Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12121 Wheeling Ave. 20772 by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify: Specify: Black. 3 TyWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed w n and Mental Hygier is marked other th 11th Domestic Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Gardner Della Rhea 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: if item 27 is m Gail J. Cook/Daughter 3515 Saratoga Ave., Annapolis, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 17 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury Lincoln Memorial Cem. 6/7/2007 Suitland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home any 4001 Benning Rd., NE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End stage Remainded Cause. Wash., DC 20019 Approximate Interval Between Onset and Death **Physician** Due to (or as of nsequence of): Unk own /Medical Examiner Cong MTin anknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to as a consequence of): Examine certificate be executed and burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No page 2 autopsy performed certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 🔀 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After 1 Certification: 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hou. the Funeral Dire Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2 Registrar

Medical

31. Date filed (Month, Day, JUN 0 7 2007

29b. Signature and title of certifier

(Check only one)

FARAHIFAR 32. Registrar's Signature

M.D

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9801

29c. License number

D43446

29d. Date signed (Month, Day, Year)

6.2.07

Georgia Ave Suit 3-41 Silversprighozoga

07-04120 James T. Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ames 1. Smill			rtificate of Death	Reg. No.	
Physicia Aedical Examir	ın/	Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death 0055 hrs
REDICAL EXAMIN		JAMES TYRONE SM 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Month Day Year May 31, 2007	
		S/B I95 /Ritchie Marlboro Road	District Heights	Prince George	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. is 220-86-8250 1X M 2 F 37	ast birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	Foreign	thplace (State or gn/ARYLAND suntry)
any.		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Location	<u> </u>	10d. Inside City Limits
* !	ö	MD PRINCE GEORGE'S I	ANHAM		1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once,	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cou	ntry?
ith the		7 3 0 6 GOOD LUCK ROAD 11. Marital Status 12. Was Decedent Ever in U.	2.0706 S. 13. Was Decedent of Hispanic Origin? (Sp	U.S.A. ecify Yes or No-	ican Indian, Black,
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto		
safter c	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:	Specify:	BLACK
5-0036 led within 72 hours a Hygiene. other than "natura the Medical Exami	ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of v during most of working life. DO NOT use retired.)		industry
036 ithin 7 ene. rr than	Completed	11th	TRUCK DRIVER	PRIVATE	
		17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Surname)	
2121 2121 Juld be fi Mental marked ic event,	To Be	JAMES P. SMITH 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or F		e, Zip Code)
imore, MD 2 Pages I and 2 shoument of Health and I rant: If item 27 is no other traumatic		THELMA CAGER /MOTHER	7306 GOOD LUCK ROAD I		
Ore, es l an of Hez If itel		1 2 Burial 2 Cremation 3 Removal from State	Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City o	
Baltimore, permit. Pages I an Department of He. Important: If ite injury or other tr		4 Donetton 5 Other Specify: 2 ignature of Fune 1 ervice Licensee	00 Name and Address of Facility	7/2007 LANDOVER,	
Ba perm Depa Imp	1	18	7474 LANDOVER ROAL	B. JENKINS FUNERA D LANDOVER, MARYLAN	L HOME D 20785
Physician 'Medical		failure. List only one cause on each line.	. Do not enter the mode of dying, such as cardiac o	r respiratory arrest, shock, or heart	Approximate Interval Between Onset and
caminer	8 10	Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of the control of the cont	yf)·		Death
		Sequentially list conditions, b			
	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated (Disease or injury that Initiated	nf):		
uted nd ransit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of d.	of):		
60, ate be executed hysician and re burial - transit	Medical	UNPENDED AMENDED			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – transi	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant in the Pregnant at time of do	2 Fetal death 3 Ectopic pregna	23d. Date of delive Month	ry Day Year
J. Bo I the deal by the all	Phys	Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not or	resulting in the underlying cause given in Part I	23e. Did tobacco use contribute to	the cause of death?
rires that the signed by	<u>ā</u>	Tark in Other Significant Containors	osalang in the anashying cases given in tare in		obably 4 Unknown
ords, w require	Completed				utopsy findings available completion of cause of
teco he law ate has age 2 s	dwo			performed? death?	
tal Rec	Bec	25. Was case referred to medical examiner?	26.Place of Death (Check		
Physic Physic er this	ဥ	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 27. Manner of Death 28a. Date of Injury	ER/Outpatient 3 DOA Nursir 28b. Time of Injury 28c. Injury at Work?	ng Home 5 Residence 6 Oth	er: Scene
On of or anding Phath.	tion:	1 Natural 5 Pending (Month, Day Year) May 31, 2007	0038 hrs 1 Yes 2 ✔ No	Operator of motorcycle involv	ed in collision
Division of Vital Records, P.O. tal or stending Physician: The law requires that the safter death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	Certification:	Suicide Could not be determined (Specify) Major Pool	nome, farm, street, factory, office building, etc.	28f. Location (Street and Number or F or Town, State) S.B 195 /Ritchie Marlboro Road, D	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowled	dge, death occurred at the time, date and place, and and/or investigation, in my opinion, death occurred a	due to the cause(s) and manner as sta	ated.
To the within 2 To the complet	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (M	
	-5	Great -	O.C.M.E.	May 31, 2007	
RB)		30. Name and address of person who completed cause of death (Iter Ana Rubio MD. Assistant Medical Examiner	111 Penn Street, Baltimore, MD 2120	1	
	ate	31. Date filed (Month, Bay Year) 32. Registrar's Sign	iline ,		
Regis	trar	JUNU 1 EUVI BREWY No. 1975			

07-0

Sasl

)4384	ıh Ct	ov din	Please Type or Print in Black Indelible Ink. Ensure State of Maryland / Department of Health and	: All Copie I Mental Hy	ygiene	Die.	007 1557
ha Elizabet	เท อเ	1- F	For State Certificate of Death		Reg.	No.	2 Time of Dooth
Physic	ian/		gistrar Decedent's Name (First, Middle,Last)		2. Date of Death Month D	ay Year	3. Time of Death 0900 hrs
l Exan		1 5	Sasha Elizabeth Stavins 4b. City, Town, or L	Location of Death		4c. County of	Death
		4a	a. Facility Name (if not institution, give street and number) 4b. City, Town, or U Rockville			Montgom	ery
Funera	1	5.	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year				g. Birthplace (State or Foreign
Directo		'	256-78-5175 1 Months Days	Hours Min	8/20/1	993	Country) MD
			sual Residence of Decedent 10c. City, Town or Location				10d. Inside City Limits
ow any	.01	10	Oa. State MD Montgomery Rockville				1 X Yes 2 No
ryland		10	0e. Street and Number 10f. Zip Code			g. Citizen of Wh	
ith the Maryland 23a or 28a-f show	Director		6100 Tilden Lane 2085			nited S	- American Indian, Black,
with 1	pe no	1	1. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of His If Yes, specify Cuban	spanic Origin? (S n, Mexican, Puerto	specify Yes or No- o Rican, etc.)	White	
r death or ite	must be no		Armed Forces / 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No	specify:		Specify:	Eurasian
irs afte	mine	ઽ⊢	Widowed Divorced If Yes, Give Year 163 2 165 2 165	ition (Give kind of	work done	16b. Kind of Bu	siness/Industry
72 hou	al Exg		Elementary/Secondary (0-12) College (1-4 or 5+) Student		16 16	Educa	tion
0036 within iene.	Medic	nalaidulo 1	6 17. Father's Name (First, Middle, Last)	18.Mother's Nam	ne (First, Middle, M		
21215-0036 Juld be filed within 72 IMental Hygiene.	the state of	, ا د	Ralph Stavins	Chong			7 0-11
ore, MD 21215-0036 set 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "naturial", or items 23a or 28a-f sho	à .	<u>n</u>	19a. Informant's Name/Relationship (Type, Print) Ralph Stavins - Father 19b. Mailing Address (Streen and Pather and Pather) 19b. Mailing Address (Streen and Pather) 19b. Mailing Address (Streen and Pather) 19b. Mailing Address (Streen and Pather) 19b. Mailing Address (Streen and Pather) 19b. Mailing Address (Streen and Pather) 19b. Mailing Address (Streen and Pather) 19b. Mailing Address (Streen and Pather) 19b. Mailing Address (Streen and Pather) 19b. Mailing Address (Streen and Pather) 19b. Mailing Address (Streen and Pather) 19b. Mailing Address (Streen and Pather) 19b. Mailing Address (Streen and Pather) 19b. Mailing Address (Streen and Pather) 19b. Mailing Address (Streen and Pather) 19b. Mailing Address (Streen and Pather) 19b. Mailing Address (Streen and Pather) 19b. Mailing Address (Streen and Pather) 19c. Mailing Address (Streen and Pat	et and Number or Lane Ro	r Rural Route Num ockville	ber, City or Tow MD 2085	vn, State, Zip Code)
re, MD ss 1 and 2 sho of Health and If item 27 is	auma		20b. Place of Disposition 20b. Place of Disposition (Name of ce		Date		- City or Town, State
ore Silver Tri	ther tr		1 XBurial 2 Cremation 3 Removal from State Judean Memorial	1	5/10/07	01ney	, MD
Baltimore, permit Pages 1 an Department of Hea Important: If ite	y or 0		22. Name and Address	ss of Facilit AI.	izansky-	oldberg	Memorial
Ba Perm Depa Imp	:	- 1	Chapels 1				Rockville M52
hysici		12	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying failure. List only one cause on each line.	myocorditi	s of the co	onduction	Between Onset and Death
Medic Examin	_		Immediate Cause (Final disease or condition resulting in death) Acute bronchopneumonia with focal r Due to (or as a consequence of): system of heart	myccararer	3 OF THE C	oridae e 1 o 1	
			Sequentially list conditions, b.				
		iner	if any, leading to immediate Due to (or as a consequence or).				
<u> </u>	sit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				4
xecute	tra	18	X UNPENDED X AMENDED #2, perME, 9871, 9/21/07 TF #5perfH6/15/07, BMW, MOCOFF #	1 23a PTT.	.27.perME.g	870.8/13	3/07 TT
30, te be e	the attending pnysician ed for use as the burial	ed	IE FEMALE: 23c. If yes, outcome of pregnancy			23d. Date Month	of delivery Day Year
687 ertifica	aing p	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Specify)	3 Ectopic pre	gnancy	World	Suj
Box 68760, seenth certificate be	e atten for us	Physici	1 Yes 2 V No 9 Unknown g Unknown		00- Did	ioh agail coanaid	ntribute to the cause of death?
P.O. E	ゔらし		Part II. Other significant conditions contributing to death but not resulting in the underlying cause	se given in Part I.			3 Probably 4 Unknown
D mires th	n signed t	Completed by	Congenital disorder with seizures				Were autopsy findings available prior to completion of cause of
ord aw req	as bee 2 shou	plet			auto perf	ormed?	death? 1 Ves 2 No
Rec	certificate has rector, page 2 s	Com	26.Pi	ace of Death (Che		2	
ital	his certi director	Be	25. Was case referred to medical examiner? 1 V yes 2 No Hospital: Inpatient 2 ER/Outpatient 3 DOA		ursing Home 5		Other: Scene
of Vital Records,	After th funeral o	n: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. I	Injury at Work? Yes 2 No	i	e how injury occ	curred
ion ttendii death.	tor: /	atio	1 X Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office		28f. Location	(Street and Nu	mber or Rural Route Number, City
Division tal or Attendi rs after death.	I Dire	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town	State)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: completely filled in by the		4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time (Check only 1) Certifying Physician: To the best of my knowledge, death occurred at the time (Check only 1) Certifying Physician: To the best of my knowledge, death occurred at the time (Check only 1) Certifying Physician: To the best of my knowledge, death occurred at the time (Check only 1) Certifying Physician: To the best of my knowledge, death occurred at the time (Check only 1) Certifying Physician: To the best of my knowledge, death occurred at the time (Check only 1) Certifying Physician: To the best of my knowledge, death occurred at the time (Check only 1) Certifying Physician: To the best of my knowledge, death occurred at the time (Check only 1) Certifying Physician: To the best of my knowledge, death occurred at the time (Check only 1) Certifying Physician: To the best of my knowledge, death occurred at the time (Check only 1) Certifying Physician: To the best of my knowledge, death occurred at the time (Check only 1) Certifying Physician: To the best of my knowledge, death occurred at the time (Check only 1) Certifying Physician: To the best of my knowledge, death occurred at the time (Check only 1) Certifying Physician: To the best of my knowledge, death occurred at the time (Check only 1) Certifying Physician: To the best of my knowledge, death occurred at the time (Check only 1) Certifying Physician: To the best of my knowledge, death occurred at the time (Check only 1) Certifying Physician: To the best of my knowledge, death occurred at the time (Check only 1) Certifying Physician: To the best of my knowledge, death occurred at the time (Check only 1) Certifying Physician: To the best of my knowledge, death occurred at the time (Check only 1) Certifying Physician: To the best of my knowledge, death occurred at the time (Check only 1) Certifying Physician: To the best of my knowledge, death occurred at the time (Check only 1) Certifying Physician: To the best of my knowledge, death occurre	e, date and place,	, and due to the ca	use(s) and man	nner as stated. nd due to the cause(s)
o the l	omplet	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.	cense number	red at the time, da	29d. Date s	signed (Month, Day, Year)
	F 5	×		.C.M.E.		June 9,	
-			30. Name and address of person who completed cause of death (Item 23a)				
			Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Str	reet, Baltimoi	re, MD 21201		
	S	tate	32 Registrar's Signature				
R	legis	1177	THIN I I LUI WILLIAM AS AND AND AND AND AND AND AND AND AND AND				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2007 **Physician** Year Schweid June 1, 7:00 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 515 Apple Grove Rd. Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day 2/4/17 Birthplace (State or Foreign Country)
 NY **Funeral** Age (In vrs. last birthdav) Days 90 Months 1 □ M 2 🕅 F 056-09-2359 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County Montgomery 10c. City, Town or Location
Silver Spring 10a, S Md . State 10d. Inside City Limits 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? International Dr. #645 20906 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2≦ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: White 3℃ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper Private 17. Father's Name (First, Middle, Last) Hyman Herbst 18. Mother's Name (First, Middle, Maiden Surname) Be Jennie Gross ဥ 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 18046 Rolling Meadow Way Olney, Md. 208 19a. Informant's Name/Belationship (Type. Print) Irving Herbst- Brother Way Olney, Md. 20832 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Lebanon 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o once. 1 ➡ Burial 2 □ Cremation 3 □ Removal from State 6/3/07 Adelphi, Md. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
EDward Sagel Funeral Direction 1091 Rockville Pike Rockville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure years /Medical Due to (or as a consequence of) **Examiner** Hypertension years Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician Physician/Medical attending physic IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by icate has been sig 1 Yes 2 No 3 Probably 4x Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? res 2 No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death Check onl one Other: ${}_{4}\square$ Nursing Home ${}_{5}\square$ Residence ${}_{6}$ \boxtimes Other (Specify) Group Home 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury 28b. Time of 27. Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 X Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division or Vital Records, P.O. Box 68760, To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

20

State Registrar 31. Date filed (Month, Day, Year) 05 2007 NUL

Genevive

(Check only one)

Dr.

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1355 Piccard Dr. Suite 100 Rockville, Md. 20850

29c. License number

D0064615

29d. Date signed (Month, Day, Year)

6/2/07

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 9:00 p M 2007 Savelli May 31 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Home Montgomery Ammah 1 01nev If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Months Hours 1 □ M 2 🕱 F Yrs. March 20, 1914 Director 93 Italy 579-52-4873 Usual Residence of Deceden Pages 1 end 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show other traumatic event, the Medical Examiner must be putilified at 1 ☐ Yes 2 X No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number ō 5917 Halpine Road Items 23a 20851 Italy Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☒ No Specify Specify If Yes, Give Year or Dates: 3 X Widowed 4 ☐ Divorced White "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 2 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be and Mental h Sabatino Santoflaminio Olimpia D'Angelo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 Anne Savelli-Oliver - Daughter 5917 Halpine Road, Rockville, Maryland 20851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 5 Department of Important: If any injury or once. Fort Lincoln Cemetery 6/5/2007 Brentwood, Maryland 4 □Donation 5 □Other (Specify) 21. Sign tree I Fun rall Service Licenses 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on NEUMONI Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b Due to for as a consequence off Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Cther (specify) P.O. I ed by the a detached f 9 Unknown 9 Unknown s been signed be seta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by 2X No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 1 🗌 Yes Division of Vital To the Hospitel or Attending Physician: director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Other: 4 Nursing Home 5 Residence 1 Yes 2 No 6 Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28b. Time of Injury 28c. Injury at Work? 27. Manger of Drain 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending r death. 1 Tes 2 No investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Direct 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 6316 e and address of person who completed cause of death (Item 23a) (Type, Print) SH VIN 0 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 0 5 2007 Registrar

	•	1 - For State	Amend i				O.	runcai	ie oi i	Death			Reg	No.		
Diversity		1. Deced	lent's Name (First,	, Middle, Last)								2. Date of Month	Death	Day	Year	3. Time of Death
Physic /Medi			Katherin	ne Mil	ler Sh	norb						June	4,	2007		12:15 A
Exami	ner	4a. Facili	ty Name (If not ins	stitution, give s	street and numb	ber)		4b. City,	, Town, or	Location o	f Death			4c. County of	of Death	
			04 Ridgev			A == (1=	In a & b in the start		vy Ch	nase If Under 2	24 Hrs	8. Date of		Montgo		7 place (State or Forei
Funeral Director		210-	Security Number -24 - 20006	5 1 I	M 224F	76. Age (In yrs.	Yrs.		Days	Hours	Min.	(Month,	Day, Y	(ear) 1931	Coui	ntucky
and w		Usual Re	esidence of Deced	lent County		10c. Cit	ty, Town or Lo	ocation							1.	10d. Inside City Limi
f sho	ō	Mare				Ch a	Cl-									1 X □Yes 2 □ N
the 128a-	Director		71and Mor	regomer	У	CHE	evy Cha	_	ip Code				100	g. Citizen of W	/hat Cou	ntry?
3a ol	O IE	69	04 Ridge	A hoows	Ve			208	815				1	J.S.A.		
dean ms 2	Funeral	11. Marit			12. Was Deced	lent Ever in U	J.S. 13.			ispanic Orig	gin? (Spe	cify Yes or Rican, etc.)		14. Race	- Americ	can Indian,
iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If it item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fu		Never Married 2 Widowed 4 □ Di		1 ☐ Yes 2 If Yes, Give Year or Dat	2 K] No		1 ☐ Yes		Specify:	i i ucito	riioari, oto.,		Specify:		
2 hou atura cal E	ted		15. De	ecedent's Edu	cation		16a. Dece	dent's Usu	ual Occupa	ation			16	b. Kind of Bus		
Media A	Completed	Eleme	(Specify only entary/Secondary (y highest grade (0-12)	e completed) College (1-4	4or 5+)	life.	NOT u	ork done d use retired	during most d)	t of worki	ng	-			
giene giene giene , the	E O			, , , ,	5+		Kinde	rgar	ten I	[eache	er		E	ducati	on	
al Hy I othe	Be	17. Fath	er's Name (<i>First, I</i>	Middle, Last)						18. Mothe	r's Name	(First, Mid	dle, Ma	aiden Surname	e)	
Ment Ment arked attc e	2		ville Mi									ne_Wi				
2 snc and Is mi		19a. Info	ormant's Name/Re	elationship (Ty	pe. Print)		l							City or Town, S		
permit. Pages 1 and 2 s Department of Health at Important: If item 27 is any injury or other trau		-	ert H. S		Husban		6904			od Ave		nevy C		e, Mar		d_20815
ges I If ite or ot		1	thod of Disposition Burial 2XXCrem		Removal from S		cemetery, cre	matory or	other plac	i i				c. Location - C	City or 1	own, State
t. Fa tmen tant:			Donation 5 □ C			Na Na	tional					6, 07		alls C	<u>hurc</u>	h, Va.
Depar mpor nny ir		21. Sign	nature of Funeral S	Service Ligens	ee 6		2					-		ler's		-
40 = 40		000 00	villace	/ K.			-					37 77				
/Medical		Immedia disease resulting	rt1. Enter the dive ock, or heart far un ate Cause (Final or condition g in death)	ſ	Due to (o	ne Can r as a consec	th. Do not en	ter the mo	de of dyin	ıg, such as	cardiac c		y arres	t,	on D	Approximate Interval Between
Examiner	Examiner	Immedia disease resulting Sequent if any le cause. Cause (that initia	ate Cause (Final or condition	ſ	Due to (o	ne Gan	th. Do not en	ter the mo	de of dyin	ıg, such as	cardiac c	or respirator	y arres	t,	on D	Approximate Interval Between
which the price of	dical	Immedia disease resulting Sequent if any le cause. Cause (that initia	ate Cause (Final or condition g in death) tially list conditions adding to immediate the Underlying Disease or injury atted events	ſ	Due to (o	ne Can or as a consec or as a consec	th. Do not en	ter the mo	de of dyin	ıg, such as	cardiac c	or respirator	y arres	t,	on D	Approximate Interval Between
which the price of	dical	Immedia disease resulting Sequent if any, le cause. Cause (that initiresulting) IF FEMA 23b. Wa in 1 1 L	ate Cause (Final or condition g in death) tially list conditions ading to immedia the immedia Enter Underlying Disease or injury ated events g in death) Last	s, te	Due to (o	r as a consecura as a consecura as a consecura as a consecura as a consecurate as a consecu	th. Do not en teer quence of): quence of): quence of): lancy al death 3[ter the mo	cer o	g, such as	cardiac c	or respirator	y arres	t,	e of deliv	Approximate Interval Between Onset and Death
es that the death certificate be executed Medical Barrana Barrana Barrana Barrana Barrana Barrana Barrana Barrana Barrana Barrana Barrana Barrana Barrana Barrana Barrana Barrana Barrana Barrana Barrana	by Physician/Medical	Immedia disease resulting Sequentif any, le cause. Cause (that initiar resulting IF FEM/23b. Was in the 1 E 9 E	ate Cause (Final or condition g in death) tially list conditions adding to immediate the Underlying bisease or injury ated events g in death) Last ALE: ss decedent pregnihe past 12 month Yes 2 No	s, te	Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o											
 | ome pf pregn | th. Do not en | Canc | pregnancy | g, such as f Unk | cardiac c | Prim 23e. D
 | ary ary | 23d. Date
Mor | e of deliv | Approximate Interval Between Onset and Death Peath | w requires that the death certificate be executed Water and been signed by the attending physician and should be detached for use as the burial-transit | by Physician/Medical | Immedia disease resulting Sequentif any, le cause. Cause (that initiar resulting IF FEM/23b. Was in the 1 E 9 E
 | ate Cause (Final or condition g in death) tially list conditions adding to immedia: Enter Underlying Disease or injury atted events g in death) Last ALE: as decedent pregnithe past 12 month green 2 No | s, te | Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o | ome pf pregn | th. Do not en
 | Canc | pregnancy | g, such as f Unk | cardiac c | 23e. D | y arres ary | 23d. Date Mor
 | e of deliventh | Approximate Interval Between Onset and Death Peatr Day Year Day Year the cause of death bably 4 🗷 Unknown |
| W requires that the death certificate be executed Water and the detached for use as the burial-transit Wedning by the detached for use as the burial-transit | by Physician/Medical | Immedia disease resulting Sequentif any, le cause. Cause (that initiar resulting IF FEM/23b. Was in the 1 E 9 E | ate Cause (Final or condition g in death) tially list conditions adding to immedia: Enter Underlying Disease or injury atted events g in death) Last ALE: as decedent pregnithe past 12 month green 2 No | s, te | Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o
 | ome pf pregn | th. Do not en | Canc | pregnancy | g, such as f Unk | cardiac c | 23e. D
1
24a. W
 | y arres ary iid toba Yes | 23d. Date Mor | e of deliventh ibute to to to to contain to contain to contain to contain the contain to contain the contain to contain the c | Approximate Interval Between Onset and Death Peath | w requires that the death certificate be executed Wear and many the attending physician and should be detached for use as the burial-transit | Completed by Physician/Medical | Immedia disease resulting Sequentif any le cause (Cause (that initiresulting Sequenting | ate Cause (Final or condition g in death) tially list conditions adding to immedia Enter Underlying Disease or injury ated events g in death) Last ALE: ts decedent pregn the past 12 month Yes 2 No Unknown
 | s, te de de de de de de de de de de de de de | Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o | ome pf pregn | th. Do not en | Canc
 | pregnancy | g, such as f Unk | cardiac c | 23e. D 1 24a. W a p 1 Yes | y arres ary iid toba □ Yes //as an utopsy //s s **Exercises** | 23d. Date Mor cco use contri 2 \(\text{No} \) 24b. V | e of deliventh ibute to to to to contain to contain to contain to contain the contain to contain the contain to contain the contain the contain the contain the contain the contain the contain the contain the contain the contain the contain the contain the contain the contain the contain the contain the contain the contain the contain the contain
the contain the c | Approximate Interval Between Onset and Death Peath | w requires that the death certificate be executed Wear and many the attending physician and should be detached for use as the burial-transit | Be Completed by Physician/Medical | Immedia disease resulting Sequentif any le cause. Cause (that initiaresulting Part II. C | ate Cause (Final or condition g in death) tially list conditions adding to immediate the immediate of the conditions and the conditions and the conditions and the conditions and the conditions are death of the conditions are also and the conditions are cause referred to miner? | s, te
 | Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o | r as a consector as | th. Do not en teer quence of): quence of): quence of): ancy al death 3[death 5[sulting in the u | □Ectopic p □Other (s | pregnancy
 | g, such as f Unk en in Part I. | cardiac c | 23e. D 1 24a. W a p 1 Ve | id toba | 23d. Date Mor | e of delivinth ibute to t 3 Pro Vere automore to coleath? | Approximate Interval Between Onset and Death Onset and Death
Death |
w requires that the death certificate be executed Water and been signed by the attending physician and should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immedia disease resulting Sequent if any le cause. Cause (that intits resulting IF FEM/23b. Wa 23b. Wa 1 L 25. Was 9 xar 1 L 27. Man	ate Cause (Final or condition gin death) tially list conditions adding to immedia fenter Underlying Disease or injury ated events gin death) Last ALE: ts decedent pregning properties as 12 month last 12 month last 12 month last series and last 12 month last series as 2 No Unknown	s, te	Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o	r as a consecutor as a consec	th. Do not en teer quence of): quence of): quence of): ancy al death 3i death 5i sulting in the u	Canc	pregnancyspecify)cause give	g, such as f Unk en in Part I. 26. Place er: 4 \(\) Nu	of Death	23e. D 1 24a. W 1 Ye n (Check orme 5 🗷 Prim	id toba	23d. Date Mor cco use contri 2 \(\text{No} \) 24b. V	e of delivinth ibute to t 3 □ Pro Were autorior to coleath? □ Yes	Approximate Interval Between Onset and Death Onset and Death
W requires that the death cermicate be executed We are signed by the attending physician and should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immedia disease resulting Sequentif any le cause. Cause (that intit resulting IF FEM/23b. Was in t 1 2 9 Part II. C	ate Cause (Final or condition g in death) tially list conditions adding to immediate the immediate of the conditions and the conditions and the conditions and the conditions and the conditions are described by the conditions are case referred to miner? Yes 2 No ner of Death	s, te	Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o Due to (o	ome pf pregn th 2 Fettinta time of own	th. Do not en teer quence of): quence of): quence of): ancy al death 3[death 5[sulting in the u	Canc	pregnancy pregna	g, such as f Unk en in Part I. 26. Place er: 4 \(\) Nu	of Death	23e. D 1 24a. W 1 Ye n (Check orme 5 🗷 Prim	id toba	23d. Date Mor cco use contri 2 No 24b. V	e of delivinth ibute to t 3 □ Pro Were autorior to coleath? □ Yes	Approximate Interval Between Onset and Death Onset and Death
w requires that the death certificate be executed Water and been signed by the attending physician and should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immedia disease resulting Sequentif any, le cause, Cause (that interesulting) IF FEMA 23b. Was in the sulting of the sulting o	ate Cause (Final or condition gin death) tially list conditions adding to immediate the Underlying Disease or injury ated events gin death) Last ALE: us decedent pregnishe past 12 month Last ALE: us decedent pregnishe past 12 month Last ALE: us decedent pregnishe past 12 month Last ALE: us decedent pregnishe past 12 month Last ALE: us decedent pregnishe past 12 month Last Yes 25 No Other significant of the Last Accident 5 Accident 5 Accident	s, the state of th	Due to (o Due to (o	r as a consector as	th. Do not en teer quence of): quence of): quence of): ancy al death 3i death 5i sulting in the u	Ectopic p Other (s	pregnancyspecify)cause give	g, such as f Unk en in Part I.	of Death	23e. Description respirator respi	id toba	23d. Date Mor 2 No 24b. V 24b. V 27 No 1 20 Ce 6 Other injury occurrence and Number	e of deliventh 3 Pro Vere autorior to coleath? Yes er (Speciled)	Approximate Interval Between Onset and Death Onset and Death
w requires that the death certificate be executed Wear and many the attending physician and should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Immedia disease resulting Sequentif any le cause. Cause (that intit resulting IF FEM/23b. Was in t 1 L 25b. Was exar 1 L 27b. Man 1 L 27c. Man 1 L 29a. Ce	ate Cause (Final or condition gin death) tially list conditions and in the condition gin death) tially list conditions and in the condition gin death) tially list conditions and in the conditions and in the condition gin death) ALE: as decedent pregnite past 12 month last 2 month last 12 month last 12 month last 12 month last 12 month last 13 month last 14 month last 15 last	medical Pending investigation (Could not be determined	Due to (o Due to (o	r as a consector as	th. Do not en the the property of the propert	□Ectopic p □Other (s	pregnancy specify) cause give dother than the time of time of time of the time of ti	g, such as f Unk 26. Place er: 4 \(\) Nu yat k? Yes 2 \(\)	of Death	23e. D 1 24a. W a 1 1 Ye of (Check on the Sell Beschie City or and due to	y arres ary iid toba Yes //as an utopsy is all // one) esiden be how n (Stre Town,	23d. Date Mor 2 No 24b. V 2d? No 1 2ce 6 Other rinjury occurre state)	e of deliventh ibute to to to a control of the con	Approximate Interval Between Onset and Death Onset and Death
w requires that the death certificate be executed Water and been signed by the attending physician and should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immedia disease resulting Sequent fi any le cause. Cause (that initiresulting) IF FEM/23b. Was a not not not not not not not not not not	ate Cause (Final or condition gin death) tially list conditions adding to immedia the condition of the conditions and the conditions and the conditions and the conditions are conditions as a case or injury ated events gin death) Last ALE: take decedent pregnish and the past 12 month of the past 12 month of the conditions are case referred to miner? ACCIDENT TO THE CONDITION OF THE CONDITION	medical Pending investigation (Could not be determined Sertifying Phyledical Exami	Due to (o Due to (o	r as a consector as	th. Do not en the the property of the propert	Ectopic p Other (s	pregnancy specify) cause give dother than the time of time of time of the time of ti	g, such as f Unk 26. Place er: 4 \(\) Nu y at K? Yes 2 \(\) I me, date an ppinion, dea	of Death	23e. D 1 24a. W a 1 1 Ye of (Check on the Sell Beschie City or and due to	y arres ary id toba Yes /////////////////////////////////	23d. Date Mor 2 No 24b. V 2d? No 1 2ce 6 Other rinjury occurre state)	e of deliverable of the state o	Day Year the cause of death' bably 4 XUnknot oppy findings avails impletion of cause 2 No fify) al Route Number, stated. to the cause(s)
ring Physician: The law requires that the death certificate be executed When this certificate has been signed by the attending physician and When the certificate has been signed by the attending physician and When the physician and the price of the control of the control of the certificate of t	edical Certification: To Be Completed by Physician/Medical	Immedia disease resulting Sequent if any le cause. Cause (that initit that initial tha	ate Cause (Final or condition gin death) tially list conditions adding to immedia the condition of the conditions and the conditions and the conditions and the conditions are conditions as a case or injury ated events gin death) Last ALE: take decedent pregnish and the past 12 month of the past 12 month of the conditions are case referred to miner? ACCIDENT TO THE CONDITION OF THE CONDITION	medical Pending investigation (Could not be determined Sertifying Phyledical Exami	Due to (o Due to (o	r as a consector as	th. Do not en the the property of the propert	Canco Ca	pregnancy specify)	g, such as f Unk 26. Place er: 4 \(\) Nu yat K? Yes 2 \(\)	of Death	23e. D 1 24a. W a 1 1 Ye of (Check on the Sell Beschie City or and due to	id toba Yes Yes Ary id toba Yes As an Yes As an A	23d. Date Mor cco use contri 2 No 24b. V P 3 No 1 ce 6 Other injury occurre ret and Number State)	e of deliventh ibute to to a significant of collecting the collecting of the collec	Approximate Interval Between Onset and Death Onset and Death
W requires that the death certificate be executed Water and the detached for use as the burial-transit Wedning by the detached for use as the burial-transit	edical Certification: To Be Completed by Physician/Medical	Immedia disease resulting Sequent fi any, le cause. Cause (that initiresulting) IF FEM/23b. Was a summer and the sequent fine fill of the sequent fill of the sequen	ate Cause (Final or condition gin death) tially list conditions adding to immedia the condition of the conditions and the conditions and the conditions and the conditions are conditions as a case or injury ated events gin death) Last ALE: take decedent pregnish and the past 12 month of the past 12 month of the conditions are case referred to miner? ACCIDENT TO THE CONDITION OF THE CONDITION	medical Pending investigation Could not be determined Certifying Physical Examination Certifier Certifier Certifier	Due to (or Due to (or	r as a consector as	th. Do not entered the Do not en	Canco Ca	pregnancy pregna	g, such as f Unk 26. Place er: 4 \(\) Nu yat K? Yes 2 \(\)	of Death	23e. D 1 24a. W a 1 1 Ye of (Check on the Sell Beschie City or and due to	id toba Yes Yes Ary id toba Yes As an Yes As an A	23d. Date Mor 23d. Date Mor 24b. V 24b. V 27d. No 1 24b. V 27d. No 1 24b. V 27d. No 1 24b. V 27d. No 1 24b. V	e of deliventh ibute to to a significant of collecting the collecting of the collec	Approximate Interval Between Conset and Death De

1. Decedent's Name (First, Middle, Last)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2. Date of Death

MONTROSE RD, ROCKVILLEMO 20852

3. Time of Death

DHMH 17 Rev 1/2001

State

Registrar

6121

30. Name and address of person who completed cause of death (Item,23a) (Type, Print)

ATEG MO.

Registrar's Signature

0

0 5 2007

31. Date filed (Month, Day, Year)

JUN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) аМ May 31, 2007 2:40 G. William Sollott 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 81 June 30,1925 Pennsylvania 207-12-4701 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 No Bethesda Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5225 Pooks Hill Rd. #1629 South United States 20814 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No
If Yes, Give
Year or Dates: WWII 1 ☐ Never Married 2 X Married Specify: Caucasian 1 ☐ Yes 2 🖾 No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Realtor 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Samuel Sollott Josephine Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5225 Pooks Hill Rd. #1629 South, Bethesda, MD 20814 Shirley W. Sollott / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 6/5/2007 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Livense

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Directo

Funeral

by

Completed

Be

ပ္

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linity or other traumatic event, the Medical Examiner must have accepted

Baltimore, Maryland 21215-0036

physician and the burial-transit physician within 24 hours after death

To the Funeral Director:
completely filled in by the

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

- 11	_
	ca
	edic
ji,	N
	cia
	Phvs
	효
	á
	stec
	Con
	Be (
	0
	ڃٰا
	ايّا
	100

Medical Certifica

State

Registrar

	1040	ROCKVIIIE PIK	e, Kocky	TITE, M.	aryland 20032
23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	cations that caused the death. Do not enter the ne cause on each line.	mode of dying, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
Immediat Cause (Final disease or condition	a Pancreatic Cancer				Office and Dodgi
resulting in death)	Due to (or as a consequence of):				
Sequentially list conditions,	b Due to (or as a consequence of):				
if any, leading to immediate cause. Enter Underlying					
that initiated events resulting in death) Last	Due to (or as a consequence of):				
	d				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		pic pregnancy er (specify)		23d. Dat Mo	e of delivery nth Day Year
Part II. Other significant conditions co	ontributing to death but not resulting in the underly	ving cause given in Part I.	23e. Did t		ribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
			24a. Was auto perfo 1∐ Yes	ormed?	Were autopsy findings available prior to completion of cause of death? □ Yes 2□ No
25. Was case referred to medical examiner?		26. Place of De	ath Check onl	one	
1 ☐ Yes 2 ☒ No	Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing I	Home 5□Resi	dence 6 □Oth	er (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? 1 Tyes 2 No	28d. Describe	how injury occur	red
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, street, f building, etc. (Specify)	actory, office	28f. Location (City or To	Street and Numb wn, State)	er or Rural Route Number,
29a. Certifier 1 X Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best of my knowledge, death occ liner: On the basis of examination and/or investi and manyer stated.	urred at the time, date and plac gation, in my opinion, death occ	ee, and due to the curred at the time,	cause(s) and ma , date and place,	anner as stated. and due to the cause(s)
29b. Signature and title of certifier		29c. License number		29d. Date signe	d (Month, Day, Year)
	X	D62571		5/31/2	007

To the Hospital

1500 Forest Glen Road, Silver Spring, Maryland 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

Sarah Jean Bromeland

05

31. Date filed (Month, Day, Year)

			State of Marylar For State Registrar	nd / Depa		ealth and M	ental Hyg	giene	0.0	Jie.	1	000000
				Cel	rillicate of L	realli		Reg. No.	5 6	- 1	Lo Time	5 0 0
- K**	Physicia	an I	1. Decedent's Name (First, Middle, Last)				Date of Dea Month	Day		Year	3. Time o	
	/Medic		Robert Myers Strong				June 3	· -	007		6:10	a ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I			4c.		of Death		
		60	Holy Cross Hospital		Silver Sp		0 D-4 (Dist		MO	ntgor		
	Funeral		1137M 2□F	s. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birtl (Month, Day	y, Year)			lace (State try)	
١.	Director		218-24-3074 77 Usual Residence of Decedent				arch 30), 19	130	Ма	ryland	ı
	and w			ity, Town or Lo	ocation					1	0d. Inside C	ity Limits
	/laryl f sho ed a	ō	Maryland Montgomery	Silv	er Spring						1 🗆 Yes	2 No
	the 1 28a- notifi	rect	10e. Street and Number		10f. Zip Code			10g. Citi	zen of W	/hat Cour	ntry?	
	with ta or	Ö	2901 S. Leisure World Blvd.,	#409		20906			TI	SA		
	eath	Funeral Director	11. Marital Status 12. Was Decedent Ever in U		Was Decedent of His If Yes, specify Cubar		ecify Yes or No-		14. Race	e - Americ	an Indian,	
	fter d	ᇤ	Armed Forces? 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No				Rican, etc.)			k, White,		
38	urs ar al", or ixam	by	If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1 ☐ Yes 2 🗷 No	Specify:			Specify.	Whi	Le	
215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	ted	15. Decedent's Education	16a. Dece	dent's Usual Occupa	tion	ng I	16b. Ki	nd of Bu	siness/In	dustry	
215	hin 7 9. an "r Mea	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	- life.	kind of work done do DO NOT use retired)	aring most of work.	''g		_	_		
21	d wit	Ö	Elementary/Secondary (0-12) College (1-4or 5+) 5+		Lawyer			_			rnment	:
b	al Hy otho vent,	To Be Completed	17. Father's Name (First, Middle, Last)			18. Mother's Name			Surnam	e)		
/lai	uld b Ment Irked Itic e	2	Woodrow F. Strong				.a L. My					
Maryland	sho and l		19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street a	nd Number or Rura	al Route Numbe	er, City o	r Town,	State, Zip	Code) 20)906 M
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	١,	Sharon L. Strong/Wife									
Baltimore,	es 1 of He fiten				osition (Name of matory or other place		oate ie 6,	20c. Lc	cation -	City or To	own, State	
Ĕ	Pag nent ant: I		4 □ Donation 5 □ Other (Specify) Me	tropol	itan Crema			Alexa	andr	ia,	Virgir	nia
alti	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee	f	2 Name and Addres	séfacility Collins	Funeral	l Hoi	ne I	nc.		
Ω	8 3 5 6	9.2	Aans slow	5	00 Univers	sity Blvd	, W., S	Silve	er S	prin	g, MD	20901
			23a. Part1. Enter the disease, or complications that caused the des shock, or heart failure. List only one cause on each line.	ath. Do not en	ter the mode of dying	g, such as cardiac o	or respiratory ar	rrest,			Approxima Interval Be	etween
(Physician	W P	Immediate Cause (Final disease or condition a Respirator)	Failu	re					- 1	Onset and l Weel	
	/Medical		disease or condition resulting in death) a. Respirator Due to (or as a conse		-							
	Examiner		Sequentially list conditions b. Chronic Obs	structi	ve Pulmona	ary Disea	se				Decade	<u> </u>
	D +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	iquenes of):								
	be executed ician and burial-transit	Examiner	that initiated events c.									
60,	e exe lan a urial-l		resulting in death) Last Due to (or as a conse	quence of):								
	eath certificate be executed attending physician and for use as the burial-transit	ical	d									
89	certificate iding phys se as the	Physician/Medi	IF FEMALE:		1.7702							
Box	ith ce tendi	an/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf preg		□Ectopic pregnancy					te of deliv	ery Day	Year
	e death he atten ed for u	sici	1 Yes 2 No 4 Pregnant at time of	death 5	Other (specify)				IVIO	1101	Duy	
P.0	at the I by t	Phy	9 Unknown			- la Dard I	220 Did t	obanon i	ICO COST	ributa ta t	he cause of	death?
	w requires that the de been signed by the should be detached	b	Part II. Other significant conditions contributing to death but not re	sulting in the t	andenying cause give	mmrann.					pably 4	
orc	equii	ted	Cardiomyopathy, Stroke				1 😾	165 2		3 🗆 1 10	Jably 4	
ec	law ras be	ble					24a. Was	DSV	[prior to co	opsy finding impletion of	s available cause of
Æ	The ate his page	Completed by					perfo 1∐ Yes	ormed? Ž∐ No	, .	death? 1 □ Yes	2 🗆 No	
Division or Vital Records,	Physician: The lav this certificate has al director, page 2 a	BeC	25. Was case referred to medical examiner?			26. Place of Deat	h (Check only o	one)				
>	Physician: this certific ral director,	To E	1 ☐ Yes 2 ☐ No Hospital: 1 ☑ Inpatient 2	☐ ER/Outpatie		4 □ Nursing Ho	me 5□Resi	dence	6 □Oth	er (Speci	fy)	
0 _	ner.		27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injury Work	at ?	28d. Describe	how inju	y occuri	red		
.0	Attending r death. sctor: Affer y the fune	atic	2 Accident Investigation			Yes 2 □ No						
<u> </u>	r Att	tiţi	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At building, etc. (Special Could not be building, etc. (Special Could not be building, etc.)	home, farm, st cify)	treet, factory, office		28f. Location (a City or Tox	Street ar wn, State	nd Numb e)	er or Rur	al Route Nu	mber,
	italo rs aft rai Di	Certification:				-						
	lospi I hou uner	cal	29a. Certifier 1 Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of exami									e(s)
	To the Hospital or Attendity within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	one) and manner stated.									
	To With	2	29b. Signature and title of certifier		29c. License D3	6252		290. Da	Ju	ine 3	Day, Year) , 200	7
	ib		- am cur									
_	10		30. Name and address of person who completed cause of death (It Steven T. Kariya, M.d 10605	em 23a) (Type	r, Print) d Street,	Kensing	ton. MD	208	95			
						1.01.021.9				-		
	Sta Regist		31. Date filed (Month, Day, Year) 32 degistrar's Sig	K A	macks							

			For State Registrar	State	of Maryla		artmer ertificat			d Mer	ntal H	ygiene Reg. No.		77	1993
			Decedent's Name (First, Middle,	Last)							Date of D	Death Day	, ,	Year	3. Time of Death
	Physici: /Medic		William Har	rison	Su	therla	nd				June	2,	2001		10:00 p M
	Examin	-	4a. Facility Name (If not institution,	give street and n	umber)		4b. City	Town, or	Location of De	eath		4c.	County of	f Death	
¥°			Manor Care-Pot						otomac						omery
	Funeral Director		5. Social Security Number 019-09-4480	6. Sex 1 M 2 ☐ F	7. Age (In yrs	s. last birthday Yrs.	Months	Days	If Under 24 H Hours Mi	in.		Birth Day, Yea <i>r)</i> .1, 19		Coun	lace (State or Foreign try) ecticut
	pu ,		Usual Residence of Decedent		100.0	ity, Town or L	costion							14	Od Incid- City Limite
	shov shov	_	10a. State 10b. County		100.0	ity, Town of L	ocanon							'	0d. Inside City Limits 1 ☐ Yes 2√√No
	the M	ectc	Maryland Mont 10e. Street and Number	gomery		Ke	nsing	ton Code				10a Cit	izen of Wh	at Coun	
	with a or	Funeral Director	2901 McComas A	wanua				0895				USA		iat Ooan	.,,
	ms 23	ıera	11. Marital Status	12. Was De	cedent Ever in I	U.S. 13	. Was Dece	dent of H	ispanic Ongin?	(Specify	/ Yes or N		14. Race		
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone.	by Fur	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed F ed 1 Yes If Yes, 0 Year or	2 ⊠ No Sive		If Yes, spe 1 ☐ Yes		ın', Mexican, Pu <i>Sp</i> ec <i>ify:</i>	ierto Ric	an, etc.)		Black, SpecifyW	, _{White, (} 'h i te	
-0036	hour htural		15. Decedent		Dates.	16a. Dec	edent's Usu	al Occup	ation			16b. K	ind of Bus	iness/Inc	lustry
Ò	nin 72 n "ne Medic	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed	() (1-4or 5+)	(Giv	e kind of wo DO NOT u	ork done o ise retired	during most of v f)	working					
7	d with giene or tha	E O	Elementary/Secondary (0°12)	5+			Sen	ior .	Analyst			Opei	catio	ns_R	esearch
2	al Hy l othe	Be	17. Father's Name (First, Middle, I	.ast)					18. Mother's N	Name (F	irst, Midd	le, Maiden	Surname)	
yland	ould b Ment narked	2	Howard Suther			1			Anne H				~ ~		
Z	nd 2 sh alth and 27 Is n ir traun		19a. Informant's Name/Relationsh Betsy H. Suthe		ife		_	,	and Number or Avenue						,
Ē,	item		20a. Method of Disposition		20b.	Place of Disp cemetery, cr	osition (Na	me of	e)	Date	,		ocation - C		
ащшо	Page nent c int: If	1	1 ☐ Burial 2 反 Cremation 4 ☐ Donation 5 ☐ Other (<i>S</i>			tropol			· i i	June 200	•	Alex	andr	ia,	Virginia
galti	permit. Departn Importa any Inju		21. Signature of Funeral Service	licensee	0	I .			ssc51911n	s Fu	inera				
	40 = 40		23a Part1 Enter III disease or	complications that	caused the d								_Spr	ing,	MD 20901 Approximate Interval Between
	Dhyaiaian		23a. Part1. Enter it disease, or shock, or hear failure. List Immediate Cause (Final					,	J ,		,				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	_d	Cancer o (or as a conse									-	
	Examiner		Sequentially list conditions.	b. Deme											
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate		o (oras a conse al Fibr	·	on								
,	be executed ician and burial-transit	Exar	that initiated events resulting in death) Last	C	o (or as a conse		011							_	
8/60,		dical		d											
0	ng ph as th	Med	IF FEMALE:												
o n	death certificate e attending phys d for use as the	lan/I	23b. Was decedent pregnant in the past 12 months?	1 □ Live	utcome pf preg birth 2 Pe	tal death 3	□Ectopic p		/				23d. Date Mon		ery Day Year
5	the deay y the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pre 9☐Unk	gnant at time of known	ideath 5	Other (s	pecify)							
ř.	that the ded by detac		Part II. Other significant condition	ns contributing to	death but not re	sulting in the	underlying	cause giv	en in Part I.		23e. Dio	d tobacco	use contril	oute to th	ne cause of death?
ecords,	w requires that the death certifi been signed by the attending I should be detached for use as	d by								_	1 [Yes 2	□ No (3 ☐ Prob	ably 4 🖺 Unknown
၀ ပ	law re as bee 2 sho	Completed									24a. Wa	as an topsy	24b. W	ere auto	psy findings available apletion of cause of
Ľ	sician: The law certificate has t irector, page 2 s	E O										rformed?	de	eath?	
VITAI	ysician: The is certificate hadirector, page	BeC	25. Was case referred to medical examiner?						26. Place of [Death (C	check only	y one)			
0	> .0 0	2	1 ☐ Yes 2K No	Hospital: 1] Inpatient 2[☐ ER/Outpati			4 🖎 Nursing	g Home	5 🗀 Re	sidence	6 □Othe	r (Specif	y)
	ding P		27. Manner of Death 1 Natural 5 Pending investig) (Mo	e of Injury onth, Day Year)	28b. Time Injury	of M	28c. Injur Wor 1 □	yat k? Yes 2∐No	280	I. Describ	e how inju	ry occurre	d	
VISION	Attending r death. ector: After by the fune	ficat	3 Suicide 6 Could r	ot be 28e. Pla	ce of injury - At	home, farm, s				28f.				r or Rura	Il Route Number,
5	s fter al Dire ec in b	Certification:	4 Homicide determine	bui	lding, etc. (Spec	city)					City or T	Town, State	9)		
	To the Hospital or Attending Ph within 24 hours, fier death. To the Funeral Director: After thi completely filled in by the funeral	ledical (g Physician: To t Examiner: On the and ma											
	To the vithin To the complex c	Me	29b. Signature and title of certifier	0			29	c. Licens	e number			29d. Da	te signed	(Month,	Day, Year)
	/		had	~ Mi)			d301:	32				Jun	e 4,	2007
	12		30. Name and ad res of person Rita Ghosh, M		use of death (Ite			e, #	161. Ro	ckvi	lle	MD 2	20850		
	Sta		31. Date filed (Month, Day, Year)		Begistrar's Sig				-,						<u> </u>
	Regist	rar	JUN 05	2007	Market 1	12. 1	MAN AND AND AND AND AND AND AND AND AND A								

		•	For State Registrar		tificate of L			Reg. No.		199	Ľ.
	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day	Year	3. Time of D	
	/Medic	_	Emma Virginia Sutton				June 2	2, 20		9:39	β _M
	Examin	er	4a. Facility Name (If not institution, give street and number) Suburban Hospital		4b. City, Town, or Bethe	Location of Death sda		4c. (County of Deat Montg		:
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ★ 7. Age (In yrs. Ia. 26 + 01 + 6751 96	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da April 2	y, Year)	Co	hplace (State or untry) irginia	Foreign
	yland now at		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Loc	cation					10d. Inside City	
	a-f sl	cto	Maryland Montgomery	Ker	nsington					1 Tes 2	2 X No
	th the	Director	10e. Street and Number		10f. Zip Code			10g. Citiz	en of What Co	untry?	
	23a ust b	la l	10920 Connecticut Avenue, #11		20895				USA		
	r dez tems er m	Funeral	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	. 13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 1	 Race - Ame Black, White 		
2	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. dother than "natural" or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1	l∐Yes 2.5xtNo	Specify:			Specify: Whi	te	
5	in 72 ho n "natu A dical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give life. L	lent's Usual Occupa kind of work done o OO NOT use retired,	ation <i>luring most of work</i>)	king	16b. Kir	nd of Business/	Industry	
4	with jiene r thai	E	Elementary/Secondary (0-12) College (1-4or 5+)	Resid	dent Mana	ger			Proper	ty Manag	rement
3	othe /ent,	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden	Surname)		
3	should be and Mental marked o	To B	George Stanley			Eva Mc	Cormick				
Mai y	s 1 and 2 should be filed withing thealth and Mental Hygiene. item 27 Is marked other than other traumatic event, the Mener traumatic event, the Mener traumatic event, the Mener traumatic event, the Mener traumatic event, the Mener traumatic event, the Mener traumatic event, the Mener traumatic event, the Mener traumatic event, the Mener traumatic event, the Mener traumatic event, the Mener traumatic event, the Mener traumatic event, the Mener traumatic event even		19a. Informant's Name/Relationship (Type. Print) Stanley S. Sutton/Son		g Address (Street a Collinda					,	
5	permit. Pages 1 a Department of Hes Important: If item any Injury or othe		1 Ki Burial 2 UCremation 3 URemoval from State		sition (Name of natory or other place k Cemete	rv			cation - City or		
	artme artme brtani Injury		21. Signature of Funeral Service Licensee		Name and Addres	20	007	Wash	ington,	, DC	
ă	permil Depar Impor any Ir once,		Adams & One		oncis J. O Univer					aa MD 2	0001
г			23a. Part1. Enter the disease, or complications that caused the death	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,	Tohr	Approximate Interval Betw	een
Ġ	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	of	Fusica	`				Onset and D	eath
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence)	ence of):	1 4 7101	11				-gry	,
	Examiner		metasta	tic .	renal (ell c	ancer	•		mont	h5
		Je.	if any, leading to immediate cause Enter Underlying Due to (or as a consequence of the c	ence of):							
	cutec nd ransi	Examiner	Exquerifially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
2	e exe ian a urial-l		resulting in death) Last Due to (or as a consequence	ence of):							
0/00	tificate be executed ig physician and as the burial-transit	edical	d								
<	ing page as	155	IF FEMALE: 23c. If yes, outcome pf pregnar	nev		· · · · · · · · · · · · · · · · · · ·			201 5-1	11	
	e death certifica ne attending ph ed for use as t	sician/	in the past 12 months? 1 Yes 2 No	death 3	Ectopic pregnancy Other (specify)				23d. Date of del Month		ear
-	w requires that the desibeen signed by the should be detached	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not result	lting in the ···	nderlying cause chr	en in Part I	23e Did+	obacco u	se contribute to	the cause of de	ath?
Ď	ires the signer of the display	b	Chronic renal failur		idenying cause give	or mir arti.	1	/		robably 4 □U	
5	requi	ted		10	200			40° 42°	79.5	6	
ב נו	e law has b e 2 sl	Completed	Myleo dysplastic syn	010	46		24a. Was auto perfo	psy	24b. Were at prior to death?	utopsy findings a completion of ca	vailable use of
- -	'slclan: The law s certificate has t lirector, page 2 s	ပ်					1□ Yes	2 No	1 ☐ Yes	2 No	
2	Iclan certifi ector	Be	25. Was case referred to medical examiner?		. all Do. Othe	26. Place of Dea			_		
5	Phys this al dir	P	To yes 21200 To hattent 2 E	ER/Outpatier 28b. Time o	IL 3 DOA	4 ☐ Nursing H	ome 5 ☐ Resi 28d. Describe			ecify)	
5	ding I. After funer	ion	i atural 5 □ Pending (Month, Day Year)	Injury	Worl	k? Yes 2 □ No	Edd. Doddinge	now injury	y coodinod		
2	death ctor; y the	cat	3 Suicide 6 Could not be 390 Place of injury - At hor	me, farm, str		75 XI	28f. Location (Street and	d Number or R	ural Route Numb	per,
2	after after Direction	Certification:	4 Homicide determined building, etc. (Specify,)			City or To	wn, State,)		
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Medical C	29a. Certifier (Check only one) ertifying Physician: To the best of my know and manner stated.								
	To the vithin To the compl	Me	29b. Signature and title of certifier		29c. Licens	e number		2	e signed (Moni	th, Day, Year)	,
			30. Name and address of person who completed cause of death (Item Eric R. Brodsky, M. 10903 New	23a) (Type, W Hamp	Print) Oshire Ave	enue, Si	Lver Spr				
	Sta Registi		31. Date filed (Month, Day, Year) JUN 0 5 2007 32. Fégistrar's Signat	K A	rantes						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Of Page 1 - State Of		rtificate of Death	ano Mentai ny	/gierie Reg. No.			
ì	Physicia	an a	Decedent's Name (First, Middle, Last)			2. Date of D Month	eath Day Y	3. Time of Death		
	/Medic	al -	LEONARD	SHUCK	4b. City, Town, or Location of	06	14 2007 4c. County of			
	Examin	er	 4a. Facility Name (If not institution, give street and number WMHS - MEMORIAL HOSPITAL 	97)	CUMBERLA!	-	ALLEGANY			
1911	Funeral	test	5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)	If Under 1 Year If Under Months Days Hours	24 Hrs. 8. Date of B	irth g	Birthplace (State or Foreign		
_	Director		170-36-4753	63 Yrs.		Oct 30	0, 1943	NC NC		
	yland iow at		10a. State 10b. County	10c. City, Town or Lo				10d. Inside City Limits		
	e Man la-f sh tified	ctor	MD Allegany	Cun	nberland			1, Yes 2 No		
	vith th	Director	10e. Street and Number	. =	10f. Zip Code	10	10g. Citizen of Wh	,		
	eath v	Funeral	14106 Canal Ferry Road, S		2150 Was Decedent of Hispanic Ori		USA pecify Yes or No- 14. Race - American Ind			
9	be filed within 72 hours after death with the Maryland and Hyglene. Id either than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at		Armed Force 1 Never Married 2 Married 1 Yes, 2 If Yes, Give	¬No	Was Decedent of Hispanic Ori- If Yes, specify Cuban, Mexicar 1 Yes 2 No Specify:		Black, White, etc.			
Maryland 21215-0036	ural", o	d by	3 ☐ Widowed 4 ☐ Divorced Year or Date	s: Vietnam			Specify: white			
<u>.</u>	in 72 h "nati ledica	olete	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during mos DO NOT use retired)	t of working	16b. Kind of Business/Industry			
212	filed within 72 Hygiene. hther than "nai ent, the Medic	Completed	Elementary/Secondary (0-12) College (1-40	drive			Truck			
D	be filed tal Hygi d other event, tl	Be (17. Father's Name (First, Middle, Last)				ame (First, Middle, Maiden Surname)			
<u>₹</u>		잍	Dalton Shuck 19a. Informant's Name/Relationship (Type, Print)	10h Maili	ng Address (Street and Number	ora Smith S		ato Zin Codo)		
	175 章		Loretta Shuck wil		106 Canal Ferry			MD 21502		
Baltimore,			20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from Sta		osition (Name of matory or other place)	Date	20c. Location - Ci			
Ĕ	t. Pages tment of l tant: If Its jury or o		4 ☐ Donation 5 ☐ Other (Specify)	Rocky Gap	Veterans Cemeter	·	Flintsto	ne MD		
g	permit. Page Department of Important: If any Injury or once,		21. Signature of Funeral Service Licensee	11.	2. Name and Address of Facilit Scarpelli Funer	al Home, PA enue: Cumberl	and MD 2150	2		
r			23a. Fart1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	sed the death. Do not en				Approximate Interval Between		
ų l	Physician		Immediate Cause (Final disease or condition	MYOCARDIAL I				Onset and Death 1 HOUR		
di.	/Medical Examiner		resulting in death) Due to (or							
	- Adminion	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or	as a consequence of):						
	cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
Ď,	tificate be executed g physician and as the burial-transit		resulting in death) Last Due to (or							
68760,	cate b physic the br	edical	d							
			IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcomes the second s		_		23d. Date	of delivery		
. Box	The law requires that the death cert tte has been signed by the attending age 2 should be detached for use in	Physician/M	in the pact 12 months?	t at time of death 5	⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>		Monti	n Day Year		
J Ö	that the de led by the detached	Phys	9 ☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to deat		andorkulas esuas alvas in Port I	230 Did	tohanna usa contrib	ute to the cause of death?		
ds,	signed d be d	by	CORONARY ARTERY DISEASE	n but not resulting in the u	indenying cause given in Part I			☐ Probably 4 ☐ Unknown		
ecords,	w requires to be a signer should be a	Completed				24a. Wa	s an 24b. We	ere autopsy findings available		
r	The lav	ошо	GASTROINTESTINAL BLEEDIN	G.	· · · · · · · · · · · · · · · · · · ·	aut	opsy pri- formed de	or to completion of cause of ath? Types 2 1 No		
Vital		Be C	ANEMIA 25. Was case referred to medical examiner?			e of Death (Check only		163 22110		
o 	Physic this ce al dire	To E	1 ☐ Yes 2 No Hospital: 1 ☐ Inp			ursing Home 5 Re				
ono	ding F h. After funera	tion:	THE Matural S I criding	njury 28b. Time o Day Year) Injury	of 28c. Injury at Work? M 1 Yes 2		e how injury occurred	1		
Division	Attencer death ector:	Certification:	3 Suicide 6 Could not be 28e. Place of	injury - At home, farm, st etc. (Specify)		28f. Location	(Street and Number own, State)	or Rural Route Number,		
ב	ital or Att Ins after d ral Direct	Cert								
	To the Hospital or Attending Physician: within 24 hours after death. To the Funderal Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1. Certifying Physician: To the besi and manner and manner	s of examination and/or in						
	To the within 2 To the comple	Mec	20h Cinnelius and title of cortifies	2m /	29c. License number		29d. Date signed ((Month, Day, Year)		
)			29b. Signature and little of certifier H. Clust	aul Mr	D58853		JUNE 15	, 2007		
	4		30. Name and address of person who completed cause of DR. HABIB CHOTANI, 130 PE			AND MD	21502			
	. /		DK. HABIB CHUIANI, 130 PE	MINDIPARTH .	AATA COUDERLA	TID TID	21704			

State Registrar 31. Date filed (Month, Day, Year)

JUN 2 0 2007

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** axon 233 2007 /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Wicomico astal HOSPICE at the Lake If Under 1 Year | If Under 2 Hrs Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 **3** M 2 ☐ F 260-70-6955 Director 60 7/28/1946 GA Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Pinecone Way 21811 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces' Black, White, etc. 1 TyYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 → Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Completed by 3 Widowed 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Business Owner Golf Academy marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If item 27 Is marked or Ted Saxon ပ Mildred Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Saxon/wife Pinecone Way, Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Garden of the Pines 6/8/07 4 ☐ Donation 5 ☐ Other (Specify) Berlin, MD 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Lice 108 William St., Berlin, MD 21811 Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, and leaves. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 2 No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 2 No 1 ☐ Yes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performe Yes 2 certificate 1[Yes Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes Inpatient 2 ER/Outpatient 3□ DOA Certification: To After this funeral 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: filled in by the 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 😾 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manne the within 2

BAIDH State

31. Date filed (Month, Day, Year) JUN 0 6 2007

Name and address of person who comp

29b. Signature and title of certifier

ed cause of death (Item 23a) (Type, Print) 023 32. Registrar's Signature

Registrar

29d. Date signed (Month, Day, Year)

For AMEND#29D Per H.Y. State of Maryland / Department of Health and Mental Hygiene State Registrar AACO HEALTH DEPT. 5/30/07 CMH Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 2^{Day} **Physician** 2007 May 1:45 Thomas Edwin Steward A^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel 908 Ridgewood Street Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 1 ☑ M 2 □ F 73 9/28/1933 Maryland 214-30-6439 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 🎗 🛣 No Director MD Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 908 Ridgewood St. 21401 USA Funeral 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours afterment of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or ite 1XX es 2 No 1952 − If Yes, Give Year or Dates: 1961 1 Never Married 2 Married White Saltimore, Maryland 21215-0036 1 ☐ Yes 2XXXVo Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hallam Alexis Steward Elizabeth King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any injury or other trainonce. 908 Ridgewood Street Annapolis, MD Janet Steward 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/30/2007 Metro Crematory Baltimore, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licens Dat 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) -ONGESTIVE Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Physician/Medical Examiner The law requires that the death certificate be executed as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a a I Inknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ORONARY 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy perform HYPER certificate 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation s after dea... ral Director: Aftr 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled in within 24 hours a

To the Funeral Completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. the 29d. Date signed (Month, Day, Year) 5/29 29c. License number 29b. Signature and title of certified 360 30. Name and address of person who completed cause of death (Item 3a) (Type, Print) BESTGATE RD #102 VE MUNIN 31. Date filed (Month, Day, Year) State 3 0 2007 Registrar

			1 - For Stete Registrer	State of I	Marylan	-		nt of H te of L		and M	lental Hyg	giene leg. No.			10000
			1. Decedent's Name (First, Middle, La	st)							2. Date of Dea			Year	3. Time of Death
	Physici /Medic		Robert Leon S	tottlemve	er						June_	6			8:30 A ^M
	Examin		4a. Facility Name (If not institution, given	e street and numb			4b. City	, Town, or	Location o	f Death		4c.	4c. County of Dea		
			19670 Longmeadow				W11-4		rstow				shi		n County
	Funeral		5. Social Security Number 6. S	9x 7. F M 2 ☐ F	Age (In yrs. i	,,	Months	Days	If Under 2 Hours	Min.	8. Date of Birti (Month, Day	, Year)		Cour	
	Director		212–38–7831 Usual Residence of Decedent								Sept 2	8 19	40	Mary	<u>yland</u>
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							1	0d. Inside City Limits
	a-f s	ctor	Maryland Washi	ngton]	Hage	stow	n						1 ☐ Yes 2 No
	a with the	i Director	10e. Street and Number 19670 Longmea	dow Road			10f. Z	p Code	21742			10g. Citi:		hat Cour.S.A.	-
	death ms 2	Funerai	11. Marital Status	12. Was Decede		S. 13.	Was Dec	edent of His	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)				an Indian,
39	hours after death with the Maryland turel; or Items 23s or 28s-f show al Examiner must be notified at	Ď.	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1 Zayes 2 If Yes, Give Year or Date	□No 10-	_ [4.458	1 ⊡ Yes		Specify:	, Pueno	Hican, etc.)	1	Specify.	k, White, · Whi	
5-0036	72 ho	Completed	15. Decedent's E			16a. Dece	dent's Usi	ial Occupa	ition	of worki		16b. Kir	nd of Bu	siness/In	dustry
215	filed within 72 Hygiene. other then "nei ent, the Medic	nple	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT	ise retired)							
2	ed wi	S	12			Seni	or Ma	ateria			nator	-			Company
Maryland	iould be filed I Menta! Hygid varked other	Be	17. Father's Name (First, Middle, Last Ernest Stottl						18. Mothe		(First, Middle,				
Ž	should ind Men ind marke umatic	٦	19a. Informant's Name/Relationship	_		19b Mailir	nn Addres	s (Street a	nd Numbe		vette D				Code
	1 end 2 sho Health and tam 27 Is my	1	Sherley A. Stot		· wife						Hagerst				
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Depertment of Heatth and Mentat Hygiene. Important: If Itam 27 is marked other than "naturel; or items 23a or 28a-f show any injury or other treumatic event; the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci		te Sm	lace of Dispo emetery, cred LCNSbu	sition (Na natory or LG C1	me of other place remato	ory	6–12	-07			•	own, State Naryland
a	permit. Depertir Importa any inju		21. Signature of Funeral Service Lice	nsee		22	2. Name a	nd Addres	s of Facility	Dou	glas A.	Fie	ry I	uner	al Home
m	89 = 9		Kaitlin 30	Haso	Ky		1331	East	ern B	lvd.	N. Hag	erst	own	Mary	land 21742
			23a: Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each	sed the death n line.	n. Do not ent	er the mo	de of dying	, such as	cardiac c	or respiratory ar	rest,			Approximate Interval Between
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition	America	lent	re ca	ne	vun	ulad	d	win	T			Onset and Death
			resulting in death)		as a consequ										
		<u>-</u>	Saquantially list conditions,	b Due to (or	as a consequ	uence of):		-				_		+	
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,	,										
ó	an an rial-tr		resulting in death) Last	Due to (or	as a consequ	uence of):	-								
8760	cate be executed bhysician and the burial-transit	dicai		_ d										-	
0	e as t	0 1	IF FEMALE:												
. Box	ath ce	ician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal	death 3		regnancy				2	3d. Date Mon	e of delive	ery Day Year
o.	that the death certified by the attending detached for use as	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnan 9∐Unknowi		eatn 5L	Other (s	pecify)							
1	8 5 0	by Physi	Part II. Other significent conditions	contributing to deat	h but not resu	ulting in the u	nderlying	cause give	n in Part I.			bacco u es 2[ibute to th	ne cause of death?
Š	w require been sig should t	etec											,		
Vital Records,		Completed									24a. Was a autop perfor	sy	24b. V p d 1	Vere auto rior to cor eath? □ Yes	psy findings available impletion of cause of 2 No
Ţ.	cian: artific actor,	Be	25. Was case referred to medical examiner?	Hen-ital				0.1			(Check only or				
	Physical this cal dir	10	1 Yes 2 No 27. Manper of Death	Hospital: 1 ☐ Inp		ER/Outpatier 28b. Time o					me 5 Resid				v)
5	ttending F death. stor: After the funer	tlon	□ Natural 5 □ Pending 2 □ Accident investigatio	(Month,	Day Year)	Injury	м	28c. Injury Work 1 □ Y	?` ′es 2 ⊡ N		EGG. Describe II	Ow III July	occurre	au .	
Division of	or Attendi after death. Director: A in by the fu	Certification:	3 Surcide 6 Could not be determined	e 28e. Place of	Injury - At ho etc. (Specify	ome, farm, str	eet, facto	ry, office			28f. Location (S City or Tow	treet and n, State)	d Numbe	er or Rura	l Route Number,
	Hospitel 4 hours Funerel ely filled	Medical Ce	(Check only 2 Medical Exa	nysicien: To the be	s of examinat	wledge, deatl tion and/or in	occurred vestigatio	d at the tim	e, date and inion, deat	d place, a	and due to the d	ause(s)	and mar	nner as si	ated. the cause(s)
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner	5181 9 0.			c. License							Day, Year)
}	F ₹ F 8		I (V A)					DNA	62	32	γ	6	9,1	07	,, ,
·			30. Name and address of person who	completed cause of	of death (Item	23a) (Type	Print)	UVV	Q V	3 /	'	4	1	V /	
10	49+1		3		V51.	MA	rope	TOW	H, 1	20	2170	10			
	Sta Registr		31. Date filed (Month, Day, Year)	2007 32. Reg	strar's Signa	ture	Ing . H	1							

31. Date filed (Month, JUN 0 6 State Registrar

29b. Signature and title of certifier

2401 Research Blun Sute

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar		State of M	arytano		artment of F rtificate of a	leaith and N Death		glene Reg. No.	7 19991
	Physici	an	1. Decedent's Name (Firs.		-		тı			2. Date of Dea	_	3. Time of Death
	/Medic		4a. Facility Name (If not in	lorma	E.		11	omas	r Location of Death		4c. County of D	1:10 AM
	Examin	er		-	ashington Re		tr.	Ft. Wash			Prince G	
	Funeral Director	80	5. Social Security Number 009-07-0834	1	ex 7. Ag □ M 2 XX 87	e (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day Oct.13,	7, _{Year)} 9. 1919 Ve	Birthplace (State or Foreign Country) rmont
	and w		Usual Residence of Dece 10a. State 10b.	dent County		10c. City,	Town or Lo	cation				10d. Inside City Limits
	Mary I eho	tor	Florida Os	ceola		Kis	simmee	9				1 ☐ Yes 2 🛣 No
	death with the Maryland ms 23a or 28a-f ehow rmust be notified at	Funeral Director	10e. Street and Number 2552 Aster	Cove L	ane			10f. Zip Code	34758		10g. Citizen of What USA	t Country?
0000		by	11. Marital Status 1 ☐ Never Married 2 3 ☐ Widowed 4 ☒ D	_	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:				tispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify: V	American Indian, White, etc. White
7-0-7	within 72 hours after ene. than "natural", or ite ne Medical Examine	Completed	(Specify only Elementary/Secondary		ucation de completed) College (1-4or	5+)			oation during most of work d)	ing	16b. Kind of Busine	·
7	lled w Hygier ther th	Cor	12th 17. Father's Name (First,	Middle ast)			Home	maker	19 Mother's Nam	o /First Middle	Own Hon Maiden Sumame)	ne
and	should be find Mental Find Men	То Ве	David		mmond				Eva	Unkno		
		ř	19a. Informant's Name/R	elationship (7	уре, Print)		19b. Mailin	ng Address (Street			r, City or Town, Stat	te, Zip Code)
Ž	and 2 alth a 127 le		Lourdes Tho	mas/Da	ughter-in					issimmee	e,Fla. 347	758
Saitimore	permit. Pages 1 a Department of Hea Important: If Item any injury or othe once.		20a. Method of Disposition 1 🖾 Burial 2 🗆 Crer 4 🗆 Donation 5 🗀 C	mation 3 🗆				sition (Name of natory or other place ction Cem	etery 6/8	Date /2007	20c. Location - City Clinton,	
Dail	permit. Departr Importa		21. Signatur Funeral	Service Liceo	la f		22	Name and Addre	ss of Facility Geor Fill Road Ox	rge P. Kal kon Hill,	as Funeral 1 Maryland	Home PA 20745
	Physician /Medical Examiner	J. C.	23a. Paul. Enter the disc shock, or heart failu Immediate Cause (Final disease or condition resulting in death)	(a	norsi aconseque ML	tive ence of):	Hear.	ng, such as cardiac F Fail	or respiratory and	rest,	Approximate Interval Between Onset and Death Mmms
,00/00	tificate be executed g physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								2	egrs	
.O. BOX 0	To the Hospital or Attending Physician: The law requires that the death certify the Abours atter death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregrin the past 12 month 1 Yes 2 No 9 Unknown	iaiii	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal of	death 3	Ectopic pregnancy Other (specify)	/		23d. Date of Month	delivery Day Year
ecorus, r	equires that en signed b ould be deta	þ	Part II. Other significant of		entributing to death b		1.	// - / - /	en in Part I.	23e. Did to		te to the cause of death? Probably 4 □Unknown
	The taw resate has be page 2 sho	Completed								24a. Was a autop perfor 1 Yes	sy prior med? death	e autopsy findings available to completion of cause of h? Yes 2 \sumbox No
Z Z	ician: certific ector,	Be	25. Was case referred to examiner?		Hospital:			Oth	26. Place of Deat			
0 = 0	fo the Hospital or Attending Physician: with 24 hours after death or for the Funeral Director. After this certifical completely filled in by the funeral director, to	tlon: To		Pending investigation	28a. Date of Inju		R/Outpatien 28b. Time of Injury	28c. Injur Wor	y at k?		ence 6 Other (5 ow intury occurred	Specify)
DIVISION	al or Atten after deal I Director d in by the	Certification:	2 ☐ Accident 3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined		ury - At hon c. (Specify)	ne, farm, stre	eet, factory, office				
	To the Hospital or Attending Pwithin 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier 1 🔀 C	ertifying Phyledical Exam	ysician: To the best iner: On the basis of and manner st	f examination	rledge, death on and/or inv	n occurred at the tin restigation, in my o	ne, date and place, pinion, death occur	and due to the cred at the time, c	ause(s) and manner date and place, and	r as stated. due to the cause(s)
	To the within To the comple	ž	29b. Signature and title of	certifier	21			29c. Licens	e number	mr	29d. Date signed (M	onth, Day, Year)
			Much	and	a ta	rsa	mI	1/10	12251	1111	6/6/0	17
	(3)		30. Name an address of	1 4	N	20.70	23a) (Type,	Print) SFDL	rich D -	54.0.	2 War	17 orf, MD 206 03
, A	Sta	te	31. Date filed (Month, Day		75 @ n , Y 32. Registr	ar's Signatu	and a	- 1 1 05/1	nca yr	211 20	5 1	2603
	Registr		31. Date filed (Month, Da	2007	Barent	1. 0	se de)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 7 Month **Physician** ROBERT THOMAS 5 0530 M Tuke /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1005 pital tince 2019 If Under B. Date of Birth

(Month Day Y

JUNE 12 If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Year) 1956 WASHINGTON, DC Min. Months Davs 1**∑**M 2□ F 578-74-2085 50 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ral", or items 23a or 28a-f show Exaπiner must be notified at 1 Yes 2 □ No MD PRINCE GEORGE'S **CHEVERLY** Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20785 305 NALLEY ROAD Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 XMarried BLACK 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 "natural", or Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation filed within 72 h I Hygiene. (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) PRIVATE permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien Important: If frem 27 is marked other threamy Injury or other traumatic contents. DIRECTOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY **JACKSON** LUDLOW THOMAS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 NALLEY ROAD CHEVERLY, MARYLAND V. THOMAS/WIFE LINDA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6/12/2007 SUITLAND, MARYLAND LINCOLN CEMETERY 4 ☐ Donation , 5 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature ervi 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1 Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No detached 9 Unknown 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 No 1 TYes 2L No Hospital or Attending Physician: 25. Was case referred to medical examiner 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2⊟ER/Outpatient 3□ DOA 1 Yes 2 No 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide

within 24 hor To the Fune completely fi

State Registrar

Medical

31. Date filed (Month, Day, Year) JUN 0 7 2007

29b. Signature and title of certifier

29a. Certifier

(Check only one)

SALVADOR SYLVESTER M.D. 3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785 32. Registrar's Signature

30. Name and address of person with completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Jose Abelardo Tejada

		1- For State Registrar	•	ficate of D	eath		Reg.	No.	
Physici Pedical Exam		1. Decedent's Name (First, Middle,Last) Jose	Abelard	lo Teja	da	М	ate of Death Ionth [Ine 4, 200	Day Year 7	3. Time of Death 1920 hrs
		 Facility Name (if not institution, give street and nu 3525 Edwin Street 	mber)		City, Town, or Location ilver Spring	of Death		4c. County of Montgom	
Funeral Director		218-31-4611 1 ^X M 2 F	7. Age (In yrs. last	_	Under 1 Year If Und Months Days Hour			(MM/DD/YYYY) , 1959	9. Birthplace (State or Foreign EI ^{Country)} Salvador
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location				_	10d. Inside City Limits
* *	tor	Maryland Montgomery			ilver Sprir	ng			1 XYes 2 No
eath with the Maryland items 23a or 28a-f sho ust be notified at once.	I Director	10e. Street and Number 3525 Edwin Street			f. Zip Code 20902			Citizen of Wha	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygers of the mit. If liene 7's marked other than "natural", or items 23a or 28a-fshonr other traumantic event, the Medical Examiner must be notified at once	Funeral	11. Mantal Status Never Married Widowed 1 Divorced If Yes, Give Yea	2X No	If Yes,	ecedent of Hispanic Ori specify Cuban, Mexican s 2 No specify	n, Puerto Ricar	n, etc.)	White,	American Indian, Black, etc. Hispanic
nours afi natural' Xamine	ed by	15. Decedent's Education (Specify only highest grad	le completed) 1	6a. Decedent's U	Isual Occupation (Give	kind of work of		6b. Kind of Busi	
21215-0036 Id be filed within 72 how denial Hygiene. narked other than "nan event, the Medical Exs	Complete	Elementary/Secondary (0-12) College (1	-4 or 5+)	-	Body Mechar	nic			vate
Dre, MD 21215-0036 es 1 and 2 should be filed within 72 of Health and Mental Hygiene. If Iften 27 is marked other than her traumatic event, the Medical	Be Co	17. Father's Name (First, Middle, Last) Julian Tejada				er's Name (Firs Emelin		iden Surname) les	
MD 21 1d 2 should alth and Me m 27 is ma	7	19a. Informant's Name/Relationship (Type, Print) ROSa Figueroa (Wife)			dress (Street and Nu Win Street				
nore, MD 2 ages I and 2 shou nt of Health and N t: If item 27 is n other traumatic		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from			(Name of cemetery,	Dat			City or Town, State
Baltimore, permit. Pages I ar Department of Hes Important: If ite injury or other tr		4 Donation 5 Other Specify: 21. Signature of Funeral Service Libensee			aven Cem.	6/9/2	007	Silver	Spring, MD
		Patricia Laternor	e	9013	3 Annapolis	Road,	Lanha	m MD 20	706
(Wedical									t Approximate Interval Between Onset and Death
xaminer		er with a second	consequence of):						
	Examiner	Sequentially list conditions, if any, leading to immediate course Erner Underlying Course (Disease or injury that initiated	consequence of):						
uted nd ransit		events resulting in death) Last Due to (or as a	consequence of):						
760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED							
30x 68760, leath certificate be e attending physici for use as the buri	sician/M	23b. Was decedent pregnant in the past 12 months?	outcome of pregna irth ant at time of deatl	2 Fetal o	eath 3 Ectop	ic pregnancy		23d. Date of d Month	elivery Day Year
J. Box true death or by the attended for use	Phys	Part II. Other significant conditions contributing to				art I.	23e. Did tob	acco use contrib	ute to the cause of death?
ords, P.O. w requires that the been signed by should be detact	by								Probably 4 Unknown
cords law requ has been	Completed					— Ī	24a. Was an autopsy perform	, pri	ere autopsy findings available for to completion of cause of eath?
Vital Rec sysician: The linis certificate	e Cor	25. Was case referred to medical			26.Place of Death		1 🗸 Yes 2		Yes 2 No
'Vita' hysicis	To B	TV Tes Z HNO		R/Outpatient 3	DOA Other	Nursing Ho		esidence 6 🗸	
Division of Vital Records, tal or Attending Physician: The law require ablar death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	of Injury 2 Day,Year) 007 C	8b. Time of Injur 0000 hrs	28c. Injury at Wor 1 Yes 2 ✔	- Isub	Describe ho ject shot	w injury occurre	d
Divis pital or Atours after of	ertific	3 Suicide 6 Could not be 28e. Place	e of Injury - At hom Multi-Family		ictory, office building, e	1.00	or Town, Sta		or Rural Route Number, City
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certificate but safer death. within 24 Hora bull Directors. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier 1 Certifying Physician: To the besone) 2 ✓ Medical Examiner: On the basis of and manner standards.	of examination and						
1 1 1 2 2	Me	29b. Signature and title of certifier	e e		29c. License number	-	I	-	d (Month, Day, Year)
10		30. Name and address of person who completed caus	e of death (Item 2:	3a)	O.C.M.E.			June 5, 200	
4(5)	d b	Zabiullah Ali, M.D. Assistant Medic	al Examiner	111 Penn S	street, Baltimore,	MD 21201			
S Regis		31. Date filed (Month, Day, Year) 32. Re	gistrar's Signat	de					

UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificate o	of Death		_Reg. No).	
Physicia		Decedent's Name (First, Middle,Last)				Date of Death Month Day	Year	3. Time of Death
I Exami		.,		Thompson		Month Day June 8, 2007		1258 hrs
		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or		14	c. County of Dea Calvert	th
		5300 Leitches Wharf Road		Prince Fred			_	inthalana (State or
Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year Months Days			Fore	ignWashingtor country) D.C.
Director		212-66-7397 1XM 2 F	51 Y	rs.		10/17/1	955 °	Country) D.C.
	w///-	Usual Residence of Decedent	10c. City, Town or Loc	- tia-				10d. Inside City Limits
v any		10a. State 10b. County						1 X Yes 2 No
Jaryland 28a-f show 1 at once.	5	Maryland Charles		Waldorf		1405 0	itizen of What Co	
Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho nother traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number		10f. Zip Code		10g. C		igniti y :
with the Maryland ms 23a or 28a-f sho be notified at once.	ق ا	12604 LaPlata Road		2060			USA	Disab
	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces		Was Decedent of His If Yes, specify Cubar			White, etc.	erican Indian, Black,
deatl or ite	₽.	1 Yes 2	X No	37	<i>T</i>		Specify: B1	o als
after ral",	À	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Yes 2 X No dent's Usual Occupa		work done 116t	b. Kind of Busines	
hours natu	pa	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12) College (1-4 or	during	most of working life	DO NOT use retir			
n 72 nan " lical	l e	Elementary/Secondary (0-12) College (1-4 or		f Employ	5o		Constru	ction
yiene per ti	Completed	12 17. Father's Name (First, Middle, Last)	Pe11	LEMPIOY		e (First, Middle, Maide		
al Hy ed of	B B		Thomp	pson	Elizabe	eth		Savoy
Ments mark	To B	19a. Informant's Name/Relationship (Type, Print)	19b. Mai	iling Address (Stre	et and Number or F	Rural Route Number,	City or Town, St	ate, Zip Code)
and and 27 is matic	-	Elizabeth Thompson/Mo	ther 1260	04 LaPla	ta Road	i Waldori	E, Mary	land 20602
and tealth tem		20a. Method of Disposition	20b. Place of Disp	position (Name of ce r other place)	metery,	Date 20	c. Location - City	or Town, State
Pages I and 2 should be filted within 1.2 mous arter used ment of Health and Mettal Hygione. I ant: If item 27 is marked other than "natural", or ite or other traumatic event, the Medical Examiner must		1 X Burial 2 Cremation 3 Removal from S	Sacred	•	6/	14/07 1.	aPlata	,Maryland
it. Partiment remains a series	k.	4 Donation 5 Other Specify: 21. Signa evof Fuperal Service Licensee				dams Fune		
permit. Page Department of Important: injury or oth	ŀ.	21.55						vland 2060
ysician		23a. Part I. Enj., the disease, or complication, that cause	d the death. Do not ent	er the mode of dying	, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval
ysiciaii Vedical		failure. List only one cause on each line			;			Between Onset and Death
aminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a con						
		, h				<u> </u>		
	چ	Sequentially list conditions, if any, leading to immediate Due to (or as a con	sequence of):					
	Ų.	cause. Enter Underlying Cause (Disease or injury the oth) Location.	sequence of):					
ed nsit	Fxamine	events resulting in death) Last Due to (or as a con	sequence ory.					
cate be executed physician and the burial - transit	5	X UNPENDED AMENDED		2010 7/17	/07 mg			
e be e yslcia buria	Modical	#23a, 27, IF FEMALE: 23c. If yes, outc	28a-f, perme,	G869, 7/17/	0/ 11		23d. Date of deli	very
ifficat ng ph as the	2			Fetal death 3	Ectopic pregn	ancy	Month	Day Year
The law requires that the death certificate has been signed by the attending name 2 should be detached for use as:	Dhyeician	past 12 months?	at time of death 5	Other (Specify)				
e deat the at ed for	8	1 Yes 2 No 9 Unknown 9 Unknown				Did toba	non una contribut	e to the cause of death?
rat the	۵		ath but not resulting in t	the underlying cause	given in Part I.			Probably 4 Unknown
ires tl signe	1							e autopsy findings available
requ been	Pasalator					24a. Was an autopsy	prior	to completion of cause of
e law te has						performe		h? Yes 2 No
				26.Pla	ce of Death (Check	k only one)		
siciar is cer irecte	á	examiner? Hospital:	tient 2 ER/Outpa	itient 3 DOA	Other: Nurs	sing Home 5 Re	sidence 6 🗸 C	Other: Scene
Physical derail of	F		njury 28b. Time	e of Injury 28c. Ir	njury at Work?	28d. Describe how	v injury occurred	
nding th. :: Af	5	1 Natural 5 Pending Fnd 6/8		12:58 pm 1	Yes 2 X No	subject d	rowned	
Atter	med in by the run.	2 X Accident Investigation 28e. Place of	Injury - At home, farm,		e building, etc.	28f. Location (Stre	et and Number of	r Rural Route Number, City
alor s afte al Dir	3	3 Suicide 6 Could not be determined (Specify)				5300 Leito	hes Wharf	Rd. Prince Fred
ospital hours a uneral l	2	4 Homicide 29a. Certifier (Check only) Certifying Physician: To the best of		occurred at the time	date and place, ar			
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certiff commission of the fineral director.	Collipicaci	(Check only one) 2 Medical Examiner: On the basis of e	xamination and/or inves	stigation, in my opin	on, death occurred	d at the time, date an	d place, and due	to the cause(s)
To t	3	and manner state 29b. Signature and title of certifier	:d		ense number			(Month, Day, Year)
	"	1/10: - 0 0/1		0.4	C.M.E.	,	June 9, 2007	
		Wayne meson	U.					
	- 1	30. Name and address of person who completed cause of	л death (Item 23a)	14 Dawn Chanch	Doltimore ME	n 21201		
,	1	Margarita Karoll MD Assistant Madis		' Penn Street	paillinge, ivis			
B	Sta	Margarita Korell MD. Assistant Medic 31. Date filed (Month, Day, Year) 32. Solution 32.		11 Penn Street,	Baltimore, IVIL			

07-0409	91	
Russell	В.	Tyson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar		-	Cer	rtificate of	Deat	h			gierie	Reg. No.			
	hysicia		Decedent's Nan	,		_					1	2. Date of Dea	ath Day	Year	3	Time of Death
edical	Exami	ner	1100001111		SON, JR.							Month May 30, 2	2007			0600 hrs
				(If not institution, orge's Hospit	give street and number)		[4	Chev		Location of	Death			county of E		
Fu	uneral		5. Social Security	Number 6	6. Sex 7. Age	(In yrs. la	ast birthday)	If Und	er 1 Year	r If Under	24Hrs.	8. Date of B	rth(MM/DI			lace (State or
Di	rector		578 88		1 X M 2 F	۷	Y1 Yrs.	Month	s Days	Hours	Min.	09/25	/1965	5	oreign NOR	THE CAROLINA
	28a-f show any datonce,		10a. State	10b. County			Town or Location	on		-						0d. Inside City Limits
/land	-C sho	tor	MD 10e. Street and No		GEORGES	OXC	N HILL	101 7	0				10 0'''	(147) - 1		
e Mar	or 28a	Director						10f. Zip					10g. Citize			
vith th	s 23a or 28a-f show		1008 FE	NWOOD A	12. Was Decedent	Ever in U	S. 13. Was	20745 U 13. Was Decedent of Hispanic Origin? (Specify Yes or No-						UNITED STATES 14. Race - American Indian, Black,		
eath v	item ust be	Funeral	1 X Never Mari		ried Armed Forces?	X No				, Mexican,				White, e		
after d	al", or ner m	by Fi	3 Widowed	4 Divo	rced If Yes, Give Year or Dates:	Y NO	1	Yes 2	X No	specify:			S	pecify: B	LAC	ζ
hours	Exam	ed k	15. Decedent's E		fy only highest grade com		16a. Decedent during mo			ion (Give ki DO NOT u			16b. Kir	nd of Busin	ess/Inc	ustry
36 in 72	han "	Completed	Elementary/Sec 1 12TH	ondary (0-12)	College (1-4 or 5	>+)	CHEF						DI	RIVAT	F	
-00 d with	ygiene other 1 ne Me	Com	17. Father's Name	e (First, Middle, I	_ast)		CHEF			18.Mother's	Name ((First, Middle,				
21215-0036 uld be filed within 7	rked ent, t	Be		BEA TY	SON, SR.					BESS	SIE	BERTH				
The state of the s																
, MD and 2 sho	ealth a lem 27 fraum		20a. Method of Di		BLE / MOTHE		Place of Disposi				٤,	OXON H			207	wn, State
Baltimore, permit. Pages 1 ar	it of H		1 X Burial 2	Cremation	3 Removal from Sta	ite	crematory or oth	ner place)		06.16					
I ltim	artmen ortan ry or	0 8	4 Donation 21. Signature of F	5 Other Spe uneral Service L		RE	SURRECT:					J5/200. L HOME		LINTO		
B	ii. P co	g i	Q.P.	Ma	moll					CLAND			TLANI			
	sician			the disease, or conly one cause o	complications that caused on each line.	the death	. Do not enter th	ne mode	of dying,	such as ca	rdiac or	respiratory a	rest, shock	k, or heart		Approximate Interval Between Onset and
	edical ıminer	8 1	Immediate Cause or condition result		a. Sharp Force Inju		.0									Death
			Sequentially list of		Due to (or as a conse	equence o	π):									
		iner	if any, leading to i	immediate	Due to (or as a conse	equence o	of):									
	J	Examiner	(Disease or injury events resulting in	that initiated	Due to (or as a conse	equence o	of):						-			
Records, P.O. Box 68760, The law requires that the death certificate be executed	ned by the attending physician and detached for use as the burial - transit		UNPENDE		dAMENDED	<u>.</u>										
60 , ate be	hysicia e buria	Medical	IF FEMALE:		23c. If yes, outcom	ne of prec	inancy						23d.	Date of de	elivery	
687 ertifica	ding p e as th	/sician//	23b. Was deceden past 12 month		1 Live birth		2 Fet	tal death	3	Ectopic	pregnar	псу		Month	Da	y Year
Box 687 e death certific	e atten for us	ysic	1 Yes 2	No 9 Unkr	4 Pregnant at	time or de	eatri 5 Oth	her (Spe	ecify)							
at the	d by th tached	/ Phy	Part II. Other sign	nificant condition	ons contributing to death	but not r	resulting in the u	ınderlying	g cause g	given in Par	t I.	23e. Did	tobacco us	se contribu	ite to th	e cause of death?
J. P.	signe d be de	d by										1 Y	es 2 🗸	No 3	Proba	bly 4 Unknown
ords w requ	as beer shoul	Completed										24a. Wa	psy	pric	or to co	psy findings available mpletion of cause of
Rec The Iz	cate h	Som										1 ✔ Yes	ormed? 2 No		ath? ✓ Yes	2 No
cian:	certif ector,	Be (25. Was case refe examiner?	erred to medical	Hospital: 1 Inpatie		1		11.5	of Death (- ··	. []		
F Vi	ter this eral din	2	1 Yes 27, Manner of Dea	2 No	28a Date of Inju	irv	ER/Outpatient			ry at Work?		g Home 5 28d. Describe	Residen		Other:	
on C	ath. rr: Af he fun	tion	1 Natural	5 Pendii	ng FOUND: Day,Y	ear)	FOUND: 0018 hrs		11	Yes 2	No S	Subject sta	abbed a	nd cut		
Division of Vital Records, P.O.	within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach	Certification:	2 Accident 3 Suicide	6 Could	not be 28e. Place of In	jury - At h	ome, farm, stree	et, factory	y, office b	ouilding, etc		28f. Location or Town, 1400 Southe	State)			Route Number, City
lospita	4 hour unera		4 Homicide 29a. Certifier		ysician: To the best of m			red at the	e time. da	ate and plac				•		
o the	orthin 2 orthe omplet	Medical	(Check only one) 2 ✓		niner:On the basis of examiner stated.											
•	> - 0	ž	29b. Signature an	d title of certifier			·	29		e number						h, Day,Year)
	7		Cal	ull.	1	, 2			O.C.	IVI,∟.			Мау	30, 200	′	
0%	3/	7	30. Name and add		who completed cause of d ssistant Medical Ex			n Stree	et, Balt	imore, M	1D 212	201				
	Si	tate			32. Registra											

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

OCME

		•	For State Registrer	0.0.0	n iviai ytai		artment of F tificate of			eg. No.	1 13 33	,)
			Decedent's Name (First, Mide	die, Last)					2. Date of Deat	th	3. Time of Dea	ath
	Physicia		Mildred B. Totl	h					Month June	7, 200	97 8:30 F	М
Ì	/Medic Examin	aı	4a. Fecility Name (If not instituti		mber)		4b. City, Town, o	Location of Death		4c. County of I		
			Kountry Komfor	t Personal	Care Ho	ome	Friendsville			Garrett		
_	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day)	Y225) 9.	Birthplace (State or Fo	reign
	Director		185-20-5171	1 ☐ M 2 🖫 F	94	Yrs.	Months Days	Hours Min.	Feb. 27	, 1913 P	ennsylvania	a
	p		Usual Residence of Decedent		10.00						1.2.1.1.1.2.1.1	
	arytar ehow	_	10a. State 10b. Count	•		r, Town or Lo	cation				10d. Inside City Li 1 ☐ Yes 2 2	
	Ba-f	Director	MD Garr	ett	McHe	enry						
	or 2	Dire	10e. Street and Number				10f. Zip Code		1	0g. Citizen of Wha	t Country?	
	ath v	ig.	23364 Garrett				21541			USA		
	tems	Funerai	11. Marital Status	Armed Fe	edent Ever in U. orces?	S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	cify Yes or No- Rican, etc.)		American Indian, White, etc.	
36	ours after death with the Manyian ral', or Items 23a or 28a-1 ehow Examiner must be motified at	by F	1 ☐ Never Married 2 ☐ Ma 3 🖾 Widowed 4 ☐ Divorce	If Yes, Gi	V 0		1 □ Yes 2 X No	Specify:		Specify:	TuTh i to	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. d other then "natural", or Items 23a or 28a-f ehow event, it is Madical Examinar must be usuified at			ent's Education	ales.	16a Daca	dent's Usual Occup	ation		16b. Kind of Busin	White	-
1 5	n 72 ho "natur edical	Completed	(Specify only high	est grade completed)		(Give	kind of work done	during most of worki	ng	TOD. THING OF DUSIN	osa madati y	
12	with ene. ther	E	Elementary/Secondary (0-12)	College (L.P.	N .			Nursing		
0	filed Hygi ther	ပိ	17. Father's Name (First, Middle					18. Mother's Name	(First, Middle, I			
an	d be antal	o Be	John Brown					Mary	(unknow	m)		
2	mari mati	ဥ	19a. Informant's Name/Relation	nship (Tvpe, Print)		19b. Mailir	ng Address (Street	and Number or Rura	<u> </u>		te. Zip Code)	
Z	and 2 salth ar n 27 is er treu		Eric C. Martin					., McHenr		21541		
ō,	s 1 and 2 should be filed within t Health and Mental Hygiene. Item 27 is marked other then " other treumatic event, the Me		20a. Method of Disposition	, 1 11/4	20b. P	lace of Dispo	sition (Name of		ate	20c. Location - Cit	y or Town, State	
altimore,	it. Page artment o rtant: If njury or		1 Burial 2 Cremation 4 Donation 5 Other			Country Side Crematory June 12, 2007 Davidsville, PA						
喜		İ	21. Signature of Funeya Service Ujcansee 22. Name and Address of Facility Newman Funeral Homes, P.A.									
ã	Dep Imp		1 Dun	Steime	av	P	.O. Box 2	275, Grant	sville,	MD 215	36	
			23a. Part1. Enter the disease, shock, or heer failure. Li	or complications that	caused the death	n. Do not ent	er the mode of dyin	g, such as cardiac o	r respiratory arr	est,	Approximate Interval Between	
d	Physician		Immediate Cause (Final								Onset and Deat	th
3/	/Medical		Immediate Cause (Final disease or condition resulting in death) a. ind hitium Due to (or as a consequence of): All many to Senile onset mixed type 5 ears									
ч	Examiner				P in	10.	senile	onset.	mired	1 type	5 ears	
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a consequ	1	- 10		7- /	-//		
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	1								
ó	cate be executed physicien and the burial-transit	Exa	resulting in death) Last	Due to	(or as a consequ	ience of):						
8760,	cate be e ohysicien the buria	dicai		d								
9	tifica ig ph as th	led										
P.O. Box	eath certif	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregna		Ectopic pregnancy			23d. Date o		
B	ie deatl the atte	icia	in the past 12 months? 1 □ Yes 2 ② No		nant at time of de		Other (specify)			Month	Day Year	•
Ö.	that the de ed by the detached	hys	9 □Unknown `	9 Unkr	OWN					<u> </u>		
	es tha igned be del	by F	Part II. Other significant condi	tions contributing to d	leath but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribu	te to the cause of death	n ?
P	v require been si should i	ed	1000000	mellitu	5 77	e T	40		1 🗆 Y	es 2⊠No 3[☐ Probabły 4 ☐Unkr	nown
Records,	aw re as be 2 sh	Completed	ischemic	gargino o	+ /	WPL	Extrem,	ties	24a. Was a		e autopsy findings avai	lable
T.	The lav	E	Ano d	ni ni	val 1000	cular	disa		_ perior	med? dea		J G.
-												
ital	lan: artifice ctor, p	0	25. Was case referred to medical 26. Place of Death (Check only one)									
Vital	ysiclan: The is certificate hadirector, paue	o Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☑ No	pal Hospital:	Inpatient 2	ER/Outpatier	it 3□ DOA Oth		Check only or	16)	Specify Person	01
Vital	g Physiclan: er this certifice neral director, p	To Be	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 □ 28a. Date	of Injury	28b. Time of		er: 4 🗆 Nursing Ho	n <i>Check only or</i> me 5 ☐ Reside	16)	Specify) Person	01
Vital	nding Physiclan: ath. rr: After this certifice ie funeral director, p	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend	Hospital: 1 □ 28a. Date			28c. Injur Wor	er: 4 🗆 Nursing Ho	n <i>Check only or</i> me 5 ☐ Reside	ence 61 Other	specify Personi core hom	e
Vital	Jing Ph I. Atter th funeral	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Penc 2 Accident inves 3 Suicide 6 Could	Hospital: 1 □ 28a. Date (Mor stigation d not be 28e. Place	of Injury oth, Day Year) of Injury - At ho	28b. Time of Injury	28c. Injur Wor	er: 4 □ Nursing Hor y at k? Yes 2 □ No	Check only or me 5 ☐ Reside 28d. Describe he	ence 61 Other (ow injury occurred	Specify) Person Core hom or Rural Route Number,	æ
Division of Vital	tal or Attending Physician: is after death. al Director: After this certifice ed in by the funeral director, I	o Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Penc 2 Accident inves 3 Suicide 6 Coul	Hospital: 1 □ 28a. Date (Mor stigation d not be 28e. Place	of Injury oth, Day Year)	28b. Time of Injury	28c. Injur Wor M 1 □	er: 4 □ Nursing Hor y at k? Yes 2 □ No	Check only or me 5 ☐ Reside 28d. Describe he	ence 61 Other (ow injury occurred	core	æ
Vital	lospital or Attending Physician: I hours after death. "uneral Director: After this certifics sly filled in by the funeral director, I	Certification; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend inves 3 Suicide 6 Couldetel 29a. Certifier 1 Certify (Check only 2 Medical	Hospital: 1 28a. Date (Mor stigation d not be rmined 28e. Place r	of Injury oth, Day Year) e of tnjury - At ho ing, etc. (Specify e best of my kno	28b. Time of Injury	28c. Injur Wor M 1	er: 4 Nursing Holy yat k? Yes 2 No	n Check only or me 5 □ Reside 28d. Describe he 28f. Location (S City or Town	ence 6 Other (ow injury occurred treet and Number of n, State)	Core hom or Rural Route Number, er as stated.	æ
Vital	the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifice mpletely filled in by the funeral director, I	Certification; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 Accident inves 3 Suicide 6 Couldetel 4 Homicide 29a. Certifier (Check only one)	Hospital: 1 28a. Date (Mornined 28e. Place mined 28e. Pla	of Injury oth, Day Year) e of tnjury - At ho ing, etc. (Specify e best of my kno	28b. Time of Injury	Beet, factory, office n occurred at the tirr vestigation, in my of	er: 4 Nursing Hory at k? Yes 2 No	Theck only or me 5 □ Reside 28d. Describe he 28f. Location (S. City or Town and due to the ced at the time, described)	ence 6 COther (ow injury occurred treet and Number of n. State) ause(s) and manniate and place, and	or Rural Route Number, er as stated. I due to the cause(s)	æ
Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, I	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend inves 3 Suicide 6 Couldetel 29a. Certifier 1 Certify (Check only 2 Medical	Hospital: 1 28a. Date (Mornined 28e. Place mined 28e. Pla	of Injury th, Day Year) e of Injury - At ho ing, etc. (Specify b best of my kno asis of examina	28b. Time of Injury	28c. Injur Wor M 1	er: 4 Nursing Hory at k? Yes 2 No	n Check only or me 5 □ Reside 28d. Describe he 28f. Location (S City or Town and due to the ced at the time, de	pence 6 COther (owninjury occurred treet and Number of n. State) ause(s) and manniate and place, and 29d. Date signed (A	or Rural Route Number, er as stated. due to the cause(s) Month, Day, Year)	æ
Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, I	Certification; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend inves 3 Suicide 6 Couldetel 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certified 29b. Signature and title of certified 20b. Signature and title of certified	Hospital: 1 28a. Date (Morning Stigation and the ball of the puriod string Physician: To the last Exeminer: On the ball exeminer and marrier	of Injury of Injury of Injury - At he ing, etc. (Specify be best of my kno passis of examinatiner stated.	28b. Time or Injury me, farm, str wledge, deatt ition and/or in	Beet, factory, office n occurred at the fire vestigation, in my of the control o	er: 4 Nursing Hory at k? Yes 2 No	n Check only or me 5 □ Reside 28d. Describe he 28f. Location (S City or Town and due to the ced at the time, de	pence 6 COther (owninjury occurred treet and Number of n. State) ause(s) and manniate and place, and 29d. Date signed (A	or Rural Route Number, er as stated. I due to the cause(s)	æ
Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, I	Certification; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 Accident inves 3 Suicide 6 Couldetel 4 Homicide 29a. Certifier (Check only one)	Hospital: 1 28a. Date ding stigation d not be rmined 28e. Place rmined 28e. Place rmined 28e. Place rmined 28e. Place and man dier Advance on who completed cau	of Injury th, Day Year) e of tnjury - At he ing, etc. (Specify be best of my kno asis of examinatiner stated.	28b. Time or Injury me, farm, str wledge, deatt ition and/or in	Beet, factory, office n occurred at the fire vestigation, in my of the control o	er: 4 Nursing Hory at k? Yes 2 No	n Check only or me 5 □ Reside 28d. Describe he 28f. Location (S City or Town and due to the ced at the time, de	pence 6 COther (owninjury occurred treet and Number of n. State) ause(s) and manniate and place, and 29d. Date signed (A	or Rural Route Number, er as stated. due to the cause(s) Month, Day, Year)	æ
Vital	To the Hospital or within 24 hours after You to the Funeral Direction completely filled in I	Wedical Certification; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Penc 2 Accident 3 Suicide 6 Couldete 4 Homicide 29a. Certifier (Check only 2 Medica one) 29b. Signature and title of certifier 30. Name and address of person	Hospital: 1 28a. Date (Mor stigation do not be puild stigation do not be puild stigation do not be puild stigation. To the last Exeminer: On the band mar stier. Manual Manual State of the stigation of the sti	of Injury th, Day Year) e of tnjury - At he ing, etc. (Specify be best of my kno asis of examinatiner stated.	28b. Time or Injury me, farm, str wledge, deattion and/or in 23a) (Type,	Beet, factory, office n occurred at the fire vestigation, in my of the control o	er: 4 Nursing Hory at k? Yes 2 No	n Check only or me 5 □ Reside 28d. Describe he 28f. Location (S City or Town and due to the ced at the time, de	pence 6 COther (owninjury occurred treet and Number of n. State) ause(s) and manniate and place, and 29d. Date signed (A	or Rural Route Number, er as stated. due to the cause(s) Month, Day, Year)	æ
Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, in	面 Wedical Certification; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend inves 2 Accident 3 Suicide 6 Could detel 29a. Certifier (Check only one) 29b. Signature and title of certification of the certification	Hospital: 1 28a. Date (Mor stigation do not be puild stigation do not be puild stigation do not be puild stigation. To the last Exeminer: On the band mar stier. Manual Manual State of the stigation of the sti	of Injury of Injury - At he ing, etc. (Specify be best of my kno pasis of examinatiner stated.	28b. Time or Injury me, farm, str wledge, deattion and/or in 23a) (Type,	Beet, factory, office n occurred at the fire vestigation, in my of the control o	er: 4 Nursing Hory at k? Yes 2 No	n Check only or me 5 □ Reside 28d. Describe he 28f. Location (S City or Town and due to the ced at the time, de	pence 6 COther (owninjury occurred treet and Number of n. State) ause(s) and manniate and place, and 29d. Date signed (A	or Rural Route Number, er as stated. due to the cause(s) Month, Day, Year)	æ

DHMH 17 Rev 1/2001

05H-12 State

Registrar

30. Name

J. CARUSO MA

JUN 0 8 2007

31. Date filed (Month, Day, Year)

17 WESTERN MARKAND PARKWAY

MAGENTIUM, MA

STAFF NEUROSUME CON

32. Registrar's Signature

nd address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** June *2*007 7:20 ам Mildred F. Underwood /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Rose Manor Assisted Living Ellicott City Howard Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) (State or Foreign **Funeral** 1 M 2 X ^cMaryland Director 216-16-4386 85 May 21,1922 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hyglene. and the file Hyglene. The marked other than "natural", or items 23a or 28a-f show that if them 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director Md. Howard Ellicott City 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3100 North Ridge Road 21043 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Š Specify: White 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12yrs Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Pascoe ၉ Florence Eliason 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen L. Underwood/daughter 2304 Rockwell Ave. Catonsville, Md. 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Loudon Park Cemetery 6/9/2007 Baltimore ,Md. 21. Signature of Funeral Service Lio 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. MOO845 4112 Old Columbia Pike Ellicott City, Md. 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ADVANCEDO DEMENTIA 4EAAS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of Pertifier D51860

lad

State Registrar

F1514

10700 CHAATTA

#200

Courses no 21044

dress of person who completed cause of death (item 23a) (Type, Print) JOHAMAN

31. Date filed (Month, Day, Year) JUN 0 2007

ŀ.
68760,
Вох
P.O.
Records,
Vital
10
Division

			State of Manyland / Department of Health and		3	
			State of Maryland / Department of Health and 1- State Registrar Certificate of Death		77 H H 5	7 10099
		1	Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Dea	eg. No.	3. Time of Death
	Physici		William O. Wilkinson	Month	Day Year	
- A.	/Medic		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat	th UNC	4c. County of Dea	
			KENINSULA REGIONAL MEdical Center SALISBURY		Westmi	C0
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.			rthplace (State or Foreign
	Director		Usual Residence of Decedent	7/8/19		rginia
	/land		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	a-fsh iffed	tor	Maryland Wicomico Salisbury			1 ☑ Yes 2 ☐ No
	ith the	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What C	ountry?
	ath wi		807 College Lane, Apt. A 21804		USA	
	er de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	
2	ırs aft Il", or xamlı	by F	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☐		Specify: Wh:	ite
5	be filed within 72 hours after death with the Maryland Hylgiene. d other than "natural" or items 23a or 28a-f show event, the Medical Examiner must be notified at		15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business	s/Industry
<u>'</u>	thin 7 le. an "n Medi	Completed	(Specify only highest grade completed) (Give kind of work done during most of wo life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	rking		
1	ed wi ygien her th t, the	Con	7 - Supervisor Photograph			siness Forms
	l be fil ntal H ed otl	Be		me (First, Middle, I	Maiden Surname)	
,	2 should and Mer Is marke aumatic	은	Alex Wilkinson Stella 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Ri		C'' T	7. 0
2	nd 2 should be filed within alth and Mental Hygiene. 27 Is marked other than " r traumatic event, the Mec		Goldie Mae Wilkinson/wife 807 College Lane, Apr			
֭֭֭֭֝֞֝֞֝	E E E		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City o	r Town, State
2	Pages nent of l int: If it		1 □ Burial 2 ▼ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Salisbury Crematory 6/6,	/07	Salisbury	, MD
	permit. Pages 'Department of H Important: If ite any Injury or ot once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral	Home Pro	_	
1	8 2 E 8 9	1	Jane 12 periore 501 Snow Hill Rd.	, Salisb	ury, MD 21	804
		П	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial shock, or heart failure. List only one cause on each line.	c or respiratory arre	est,	Approximate Interval Between
F	hysician		immediate Cause (Final disease or condition resulting in death) a. Brilging the minimum and t			Onset and Death
ı	/Medical Examiner		Due to (or as a consequence, of):			
		er	Sequentially list conditions, if any, leading to immediate gause. Enter Underlying			
	ite be executed ysician and ne burial-transit	Examiner	Cause. Enter Underlying Cause Unsease or Injury that initiated events			
5	be executed ician and burial-transi		resulting in death) Last Due to (or as a consequence of):			
	cate by	dical	d		· <u>-</u>	
	The law requires that the death certificate ate has been signed by the attending physioage 2 should be detached for use as the to	sician/Medi	IF FEMALE: 23c. If yes, outcome pf pregnancy			
1	atten for us	cian	in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of de Month	livery Day Year
	w requires that the d	Physi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Other (specify)			
	s that ned b e deta	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
	equire en sig outd b		Coroning Artery Piscue	1 □ Ye	es 2 DATO 3 DP	robably 4 □Unknown
	has be	Completed		24a. Was ar		utopsy findings available
	The tate h	Som		autops perform 1∐ Yes 2	ned? death?	completion of cause of 2 □ No
	ician: Sertific ector,	Be	examiner:	ath (Check only one	9)	
	Attending Physician: r death. ector: After this certific. by the funeral director,	2		T	nce 6 Other (Spe	ecify)
	ding h. After fune	tion	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 2 Accident investigation 28a. Date of Injury 28b. Time of Injury 38b. Time of Injury 48b. Time of Injury 48b. Time of Injury 48b. Time of Injury 48b. Time of Injury 48c. Injury at Injury 48b. Time of Injury 48c. Injury at Injury 48c. Injury at Injury 48b. Time of Injury 48c. Injury at Injury 48c. Injury at Injury 48c. Injury at Injury 48c. Injury at Injury 48c. Injury at Injury 48c. Injury at Injury 48c. Injury at Injury 48c. Injury at Injury 48c. Injury at Injury 48c. Injury at Injury 48c. Injury at Injury 48c. Injury at Injury 48c. Injury at Injury 48c. Injury at Injury 48c. Injury at Injury 48c. Injury at Injury 48c. Injury at Injury 48c. Injury at Injury 48c. Injury at Injury 48c. In	280. Describe no	w injury occurred	
	Aften r deat ector by the	fica	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office	28f. Location (Sti	reet and Number or R	ural Route Number.
	s after al Dir	Certification:	4 Homicide determined building, etc. (Specify)	City or Town	, State)	
	tospit t hour unera		29a. Certifier (Check only only only only only only only only	e, and due to the ca	ause(s) and manner a	s stated.
1	To the flospital or Attending Physician: The living Laborate and the death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:	Medical	and mariner stated.			
í	o ¥ o ō)	_	29b. Signature and title of certifie 29c. License number		d. Date signed (Mon.	
,	"OB	-	Whome and address of passes who completed come of death (for 200) 77	9	June 4	2007
<	200		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARK TREUTH 106 Milfard St. Salisbury A	70 0	June 4, 1804	
	Stat	le	31. Date filed (Month, Day, Year) 32. Registrar's Signature		COUT	
I	Registra	ar	JUN 0 6 2007 Brown & South			
	H 17 Rev 1/20	0.4				

			For State Registrar	tate of Marylan	•	artment of F rtificate of I		, ,	ene g. No.		
	Physicia	an.	Decedent's Name (First, Middle, Last)					2. Date of Death Month	n Day Year	3. Time of Death	
1	/Medic	al .	Helen McCambridge 4a. Facility Name (If not institution, give stre	Workman		4h City Town o	r Location of Death	June	4, 2007 4c. County of Deat	5:37 p M	
	Examin	er	Montgomery Hospice-	,			ckville		Montgo		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		hplace (State or Foreign untry)	
R	Director		579-40-6289	2 k 7 F 88_	Yrs.	lillonato Bayo			1918 Wash		
	land ow It		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits	
	Mary t-f sho fied a	ţċ	Maryland Montgomer	~v	Silv	er Sprind	1			1 □Yes 2 ☑ No	
	th the or 28a e noti	Director	10e. Street and Number	· <u>/ </u>		10f. Zip Code	,	10	g. Citizen of What Co	untry?	
	ath w		14927 Hydrus Road		0 10		0906	aoifu Mas au Na	USA 14. Race - Ame	rican Indian	
36	2 should be filed within 72 hours after death with the Maryland sand Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show armsted other than "natural", or Items 23a or 28a-f show armstic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specity:	ecity Yes or No- Rican, etc.)	Black, White	e, etc.	
5-0036	72 hor	eted	15. Decedent's Educati (Specify only highest grade co	ion ompleted)	(Give	dent's Usual Occup	during most of work	in a	16b. Kind of Business/		
2121	vithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired fice Mana	1)		Emergency : Services	Medical	
9	filed v Hygie other t	ပ္ပို	17. Father's Name (First, Middle, Last)				18. Mother's Nam				
an	lid be lental rked o	To Be	Emmet McCambridge				Cecili	a Franklin			
2	ges 1 and 2 should nt of Health and Mer i if item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type. Roland J. Workman/H		nd Number or Rural Route Number, City or Town, State, Zip Code) Road, Silver Spring, MD 20906						
altimore,	Pages 1 and 2 nent of Health int: If item 27 ary or other tra		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	oval from State	emetery, cre	osition (Name of matory or other place eaven Cer	netery	une 8,	20c. Location - City or	Town, State	
Balti	permit. Page Department of Important: If any Injury or once.		21. Signature of Futeral Service Licensee	s Funera	1 Home Inc						
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,										
-	Physician		Immediate Cause (Final disease or condition	Gastrointes						Onset and Death	
Ŀ	/Medical Examiner		resulting in death)	Due to (or as a consequent	uence of):						
Ь		e	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	uence of):					-	
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Ő,	e exectian and urial-tr	Ex	resulting in death) Last	Due to (or as a consequent	uence of):						
68760,	icate be executed physician and s the burial-transit	edical	d								
			IF FEMALE: 23b. Was decedent pregnant 23c.	if yes, outcome pf pregna					23d. Date of del	livery	
P.O. Box	res that the death signed by the atter be detached for to	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown		⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у		Month	Day Year	
	s that med by e deta	by Ph	Part II. Other significant conditions contri	buting to death but not res	ulting in the u	ınderlying cause giv	ven in Part I.	23e. Did tot	pacco use contribute to	the cause of death?	
ğ	w require s been sig should b	ed b	Coronary Artery Dis	sease				1 □ Ye	es 2 No 3 Pi	robably 4 Unknown	
Records,	The fa	Completed						24a. Was a autops perforr 1 Yes	y prior to	utopsy findings available completion of cause of	
/ita	cian: ertific	Be (25. Was case referred to medical examiner?	nital		Loui		th (Check only on	e)		
or o	Physician: r this certifica ral director, p	2	1 Yes 2 No	pital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatie	III OLI DOA			ence 6 Other (Spe	Hospice	
ou	th. : After	tion	1 Accident 5 ☐ Pending investigation	(Month, Day Year)	injury	Wo	rk?]Yes 2 □ No	2001 20001120 110	an injury occurred		
Division or Vital	To the Hospital or Attending Physical Within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral displays the fun	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, st	reet, factory, office		28f. Location (St City or Town	reet and Number or R n, State)	ural Route Number,	
	e Hospita 124 hours e Funera letely fille	Medical C		ian: To the best of my kno r: On the basis of examina and manner stated.							
	To th withir To th comp	Me	29b. Signature and title of certifier	101		29c. Licens	se number 4615	2	9d. Date signed (Moni	th, Day, Year) 2007	
	10		Deveniere W/	rd Ow Fi	mi)						
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		30. Name and address of person who com Genevieve Wrobles	wski, M.D.	1355 P		rive, Roc	kville,	MD 20850		
	Sta Registi		31. Date filed (Month, Day, Year) JUN 06 2007	32 FASIstrar's Signa	ature	anti-					